Public Report
Ombudsman Investigation – Alaska Psychiatric Institute, DHSS
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Introduction

Alaska Psychiatric Institute (API) is the only state psychiatric hospital in Alaska. It provides inpatient psychiatric and primary care to patients who are in crisis. API does not determine which patients it admits. Patients are committed to API by the Alaska Court System because they are suicidal, homicidal, violent, assaultive, psychotic, delusional, or so gravely disabled by their mental illness they cannot provide for their own basic needs. API serves the most acutely mentally ill patients – the patients who cannot be treated successfully in their home communities.

API is not a stand-alone institution. It operates within the continuum of behavioral health care offered by public and private providers. It is subject to the consequences of decisions made by judges, governors, lawmakers, regulators, local hospital administrators, prison officials, law enforcement agencies, and community behavioral health centers. What happens in a single community, or in a single hospital, can have an enormous effect on the census and care provided at API. What happens at API ripples through the entire behavioral health care system.

The Alaska State Ombudsman initiated an investigation of API pursuant to AS 24.55.120 on June 20, 2018 and provided notice to the Department of Health and Social Services (DHSS) as required by AS 24.55.150. The impetus for initiating the investigation was in part the June 2018 disclosures made by the hospital Safety Officer alleging that the manner in which API staff employ seclusion and restraint, use of force, and violence in the hospital were all unlawful. The allegations of the Safety Officer were similar to those made in a then-concluding ombudsman investigation (A2017-2346), in which the Ombudsman found that a member of API staff had assaulted a patient in December 2017. The Safety Officer's assertions echoed allegations raised in a pattern of complaints to the Ombudsman about API over time.

On July 5 and 6, 2018, the Ombudsman met with API and Division of Behavioral Health (DBH) leadership in service at the time: Director Randall Burns, API CEO Ron Hale, API Medical Director Dr. Tony Blanford, and Quality Assurance Manager Jacqueline Adelman. She also interviewed other API clinical staff. She met with the Disability Law Center director and staff on

July 6, 2018 to discuss their recent notice of a protection and advocacy investigation at API under that organization's federal authority.

The Ombudsman specifically notes that violence directed toward API staff by patients is an equally serious problem that must be addressed. However, DHSS had already contracted with attorney Bill Evans to conduct a review and report on this issue when the investigation was initiated. The Ombudsman reviewed the report and interviewed Evans about his process and findings.[1] **The Ombudsman notes that the fear and trauma experienced by API staff contributes to the environment in which decisions about when and how to use restraint or seclusion are made.** This is further discussed in the proposed recommendations being made to resolve the issues raised by the allegations in this investigation.

An extensive request for information was provided to DHSS and API on July 7, 2018. An extension was requested, due to the ongoing licensing and facility audits by the Division of Health Care Services and the Centers for Medicare and Medicaid Services (CMS). The extension was granted until September 2018. The majority of the documents requested were provided by the end of October 2018. Additional information requests were made through January 2019.

The Ombudsman collected evidence from other sources, including DHSS Health Care Services Facilities Licensing and Certification (HCSFL). The Ombudsman conducted numerous interviews of API staff from most departments at the hospital (excluding purely operational functions like maintenance, food service, etc.) in July, August, September, and October 2018. Subsequent requests for information, primarily related to audit findings and plans of correction, were made in September and October 2018 and January 2019.

The Ombudsman collected information and evidence through January 2019. (Individual patient and staff complaints were investigated throughout and after this period.) DHSS and API management, through successive leadership changes in 2018 and 2019, was kept apprised of all investigatory efforts. The Ombudsman met with then CEO Duane Mayes in September and

[1] Bill Evans's report on workplace violence at API is available online at http://dhss.alaska.gov/News/Documents/press/2018/20180912_EvansReportRelease.pdf.

October; with Director Gennifer Moreau-Johnson in October; and incoming Commissioner Adam Crum on December 6, 2018.

Pursuant to AS 24.55.180, an in-person consultation with a broadly representative group of API leaders from all departments within the hospital and including direct care providers was scheduled for December 8, 2018. The purpose of this all-day meeting was to discuss the proposed findings and recommendations and provide an opportunity for informal comment and feedback from API before the Ombudsman's preliminary report was finalized and provided to DHSS. Due to the November 30 earthquake and doubts as to whether staff and facilities would be available as planned, the meeting was postponed. Intervening changes in leadership at API prevented immediate rescheduling.

The Ombudsman hosted the consultation with the agency on January 25, 2019 in Anchorage. The recommendations discussed herein were presented in detail at the consultation, and all participants provided information and comment on each one. Information from the consultation resulted in substantive changes to the initial suite of recommendations. A preliminary report of the Ombudsman's proposed findings and recommendations was provided to DHSS on February 12, 2019. DHSS provided its response and comments on March 15, 2019. This response is incorporated herein.

The Department provided no comment on the Ombudsman's findings. The Department commented on the Ombudsman's recommendations, accepting six recommendations in whole and several more in part. The Ombudsman notes, however, that the Department expressly limited its commitment to implementing the recommendations – and made no commitment to requiring Wellpath or any other private hospital management entity to implement or maintain the changes recommended:

> The responses below contemplate how The Department of Health and Social Services (DHSS or the Department) and the Alaska Psychiatric Institute (API) will implement changes while the facility is still under the control and management of the department. The Department entered into a contractual agreement with Wellpath Recovery Solutions, Inc. (Wellpath) on February 8, 2018, in part, to

> address some of the very issues discussed in the Ombudsman report. This contract provides for two phases. The first phase is a management and compliance phase and the second phase is for full management and operations (i.e., privatization). If the second phase does not come to fruition or is delayed for any reasons, the response below outlines what API will be taking on to address the Ombudsman's findings. To the extent that Wellpath takes over as contemplated in the coming months, these issues will be addressed by Wellpath as the operator of the facility how they are intended to be addressed will be included where appropriate.[2]

This report is necessarily focused on the allegations of harm presented to the Ombudsman for investigation. However, in the course of her investigation, the Ombudsman met many API health care providers who showed immense compassion for their patients, and a commitment to providing the best care possible – with the resources they are allowed. Good work happens at API, evidenced by the many patient encounters reviewed where staff responded to patients in need using best practices, kindness, and creative problem solving. Staff showed a willingness to correct problems when they understood what they were and why the specific corrective action was being implemented.

Summary of Complaints

Since January 1, 2015, the Alaska State Ombudsman has received 42 complaints specifically about API.[3] Complaints were about a variety of issues at API:

- 31% alleged maltreatment or neglect;
- 17% alleged poor or no discharge planning prior to a patient's release;
- 14% alleged unlawful commitment;
- 7% alleged patient privacy violations;
- 7% involved allegations related to treatment provided;
- 5% involved allegations about the patient grievance process;
- 5% involved allegations related to involuntary medication; and
- 21% involved other issues.

[2] DHSS Response to Preliminary Ombudsman Report, March 15, 2019 at 1.
[3] This figure is for January 1, 2015 – December 31, 2018. Most complaints about API come to the Ombudsman from Adult Protective Services (APS). It has been a long-accepted practice that, because API is a state agency, reports of harm involving patients at API are referred by APS Intake to the Ombudsman, without any further action by APS.

In December 2017, the Ombudsman received a complaint that a member of API staff had assaulted a patient. Assistant Ombudsman Jennifer Christensen investigated that complaint (discussed further below). On June 20, 2018, the API Safety Officer emailed a series of allegations to the Ombudsman, as well as the Governor's Office, Anchorage area legislators, and others. Based on the email thread, the Safety Officer had raised concerns about the way API staff were treating patients internally with API management and DHSS leadership on June 7, 2018.

During the period of time leading up to and after the API Safety Officer's complaint to the Ombudsman, the Centers for Medicare and Medicaid Services (CMS) and the DHSS Health Care Facilities Licensing and Certification (HCFLC) unit had investigated complaints about API multiple times. Relevant findings are discussed at length in this report. The fact that licensing surveys found persistent deficiencies in these areas over several years reflects the systemic nature of these problems at API.

Allegations

Based on the initial staff and leadership interviews in July 2018, the Ombudsman narrowed the scope of the investigation to three allegations:

1. Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients from use of force by API staff.
2. Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients due to violence by other patients.
3. Contrary to Law: API does not consistently comply with AS 47.30.825(d) or 42 CFR §482.13(e) in the use of seclusion and restraint.

History of API

The manner in which Alaskans experiencing mental illness (and similar health conditions and disabilities) have been treated over the past fifty years is relevant to the allegations the Ombudsman investigated. These are systemic and persistent issues affecting the hospital for decades and result in part from policy and resource decisions made relative to the larger community mental health system, including the systems that serve Alaskans experiencing intellectual and developmental disabilities, and older Alaskans experiencing Alzheimer's Disease and other dementias.

The first Alaska Psychiatric Institute was designed in the 1960s and opened in the autumn of 1962. The first patient admitted from Morningside Hospital[4] in Portland, Oregon arrived in 1963.[5] The original hospital started as a 50-bed hospital in 1962, growing to a capacity of 225 beds in 1965.[6] (The estimated state population in June 1965 was 265,200.[7])

The original hospital opened a unit for children and adolescents in 1965.[8] The hospital also developed a program for "fragile and elderly people."[9] These patients "were not really mentally ill but suffering from chronic brain syndromes having to do with small strokes, arteriosclerosis, Alzheimer's disease and related dementias."[10] In the first 30 years, the original hospital served a larger number of young patients compared to geriatric patients.[11] Alaska Native patients made up a disproportionate percentage of the patients served, compared to the general population.[12]

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[4] The history of how Alaskans experiencing mental illness and other conditions were transported and institutionalized at Morningside Hospital, a privately-run institution in Oregon, during territorial days is well-documented by *The Morningside Hospital History Project*, conducted by Karen Perdue, Judges Meg Greene and Niesje Steinkruger, and many others. Research, primary resources, and reports on *The Morningside Hospital Project* are available at http://www.morningsidehospital.com/.
[5] *The History of API, 1962-1994,* Alaska Department of Health and Social Services at 13.
[6] *See id.*
[7] "Annual Components of Population Change for Alaska, 1945 to 2018," Alaska Department of Labor and Workforce Development, Research and Analysis.
[8] *See The History of API, 1962-1994* at 15.
[9] *Id.* at 18.
[10] *Id.*
[11] *See id.* at 26.
[12] *See id.*

While the hospital was required from the beginning to provide "security and treatment for violently or criminally insane patients," the impact was minimal because "'not guilty by reason of insanity' were extremely uncommon" when the hospital opened.[13] Also, these patients were served primarily in California until the late 1970s.[14] As the law changed regarding defenses based on decreased mental capacity – and as treatment evolved for patients found not guilty due to reduced capacity or "guilty but mentally ill" – "forensic psychiatry became a fixed part of the scene" at the 225-bed hospital.[15] API "primarily cared for public sector patients, including most of the state's extremely acute and/or violent psychiatric cases."[16]

Originally, API provided inpatient psychiatric (and other types of hospital-based) care to both voluntary and involuntary (court-ordered) patients.[17] The original hospital had the capacity to serve patients "who cannot be placed or maintained with private mental health care providers for a variety of reasons."[18] With 225 beds, API also had the role of "'system catchall' due to occasional failures of outpatient programs and community hospitals to address the needs of some patients or a lack of community resources."[19]

In 1982, API had 200 beds available to serve patients statewide;[20] the estimated state population then was 464,300.[21] Between FY1979 and FY1993, **forensic** capacity in the original API decreased from 60 beds to 10 beds.[22] Between FY1987 and FY1994, the number of beds for

[13] *Id.* at 18.
[14] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report*, University of Alaska Comprehensive and Specialized Evaluation Services (June 23, 2003) at 13.
[15] *The History of API, 1962-1994* at 18.
[16] *Id.* at 26.
[17] *See id.* at 25.
[18] *Id.*
[19] *Id.* at 26.
[20] *See id.* at 14.
[21] "Annual Components of Population Change for Alaska, 1945 to 2018," Alaska Department of Labor and Workforce Development, Research and Analysis.
[22] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 14.

children and adolescents decreased from 32 beds to 12 beds.[23] In 1994, API had 114 beds available[24] to serve an estimated state population of 600,622.[25]

By 2003, the original API had the capacity to serve 74 patients, with 10 beds dedicated to forensic patients.[26] According to the Western Interstate Commission on Health Education (WICHE), in 2006, an estimated 28,684 low-income youth and 10,948 low-income adults in Alaska experienced a serious emotional or mental health disorder.[27] A later study commissioned by the Alaska Mental Health Trust Authority estimated that, in 2013, 5,550 adolescents and 21,302 adults experienced a serious emotional or mental health disorder.[28] While not all of the estimated prevalence population in these studies would necessarily require hospitalization in a given year, it shows the extent of the need for acute mental health treatment services in Alaska.

Even with the larger bed capacity, the original API experienced overcrowding and census pressures in the 1980s.[29] Patients' length of stay in the hospital decreased from an average of 29.96 days in 1983[30] to 10.80 days in 2002.[31] Concerns about "the high occupancy and an environment that encouraged the use of staff overtime, stress, and potentially reduced quality of care" led DHSS to commission two studies to identify solutions in the 1980s.[32] These studies launched a planning process (or processes) for a new psychiatric hospital that would last for more than a decade.[33]

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[23] *See id.*
[24] *See id.*
[25] "Annual Components of Population Change for Alaska, 1945 to 2018," Alaska Department of Labor and Workforce Development, Research and Analysis.
[26] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 14.
[27] *2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household*, prepared by WICHE for the Alaska Mental Health Trust Authority and DHSS (January 2008) at 5.
[28] *See Alaska Behavioral Health Systems Assessment Final Report* prepared by Agnew::Beck Consulting, LLC and Hornby Zeller Associates, Inc. (January 22, 2016) at 52-53.
[29] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 27.
[30] *See id.* at 28.
[31] *See id.* at 62.
[32] *Id.* at 27-28.
[33] *See e.g. API/MYC Major Study,* Kumin Associates et al. (1983); *Alaska Psychiatric Institute: Needs Assessment and Planning Options*, Dann & Associates, Inc. et al. (1986); *Comprehensive Mental Health Plan for the State of Alaska,* DHSS Division of Mental Health and Developmental Disabilities (1987); *API 2000 Project: Draft Report on Bed Need Estimates,* Professional Growth Systems for the Alaska Mental Health Board (1991).

A contributing factor in the reduction in patients served at API between 1980 and 2000 was the national move toward deinstitutionalization of individuals experiencing disabilities, including people experiencing serious mental illness.[34] The Community Mental Health Services Act was passed by the Alaska Legislature in 1975.[35] As utilization of public psychiatric hospitals decreased, private inpatient psychiatric services increased alongside increased "community-based rehabilitative services."[36] Still, API, like other states' psychiatric hospitals, "remained the primary treatment sites for individuals with the most severe and persistent – or the most violent – diagnoses."[37]

The Alaska State Mental Health Policy (AS 47.30.655-660) was enacted in 1981 to "protect the legal rights of individuals with mental illness, attempting to balance their right to physical liberty against the State's interest in protecting society from those who may pose a danger to others or themselves."[38] This legislation "enabled – even required – the Alaska Legislature and DHSS to fund more community-based mental health services, while continuing to fund API."[39] It also provided for the creation of designated evaluation and treatment (DET) services in local community hospitals, which were expected to provide inpatient psychiatric services for up to 30 days.[40] In 2001, DHSS added the option of designated evaluation and services (DES), which would support local community hospitals which lacked capacity for a 30-day mental health unit to still provide short-term inpatient psychiatric services (72 hours – 30 days).[41]

As part of the "API 2000" planning process, work groups of DHSS staff, members of the Alaska Mental Health Board, public and private mental health providers, advocates, and other stakeholders were created to make recommendations for the new incarnation of API.[42] The work

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[34] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 24.
[35] AS 47.30.520 *et seq*.
[36] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 14.
[37] *Id*.
[38] *Id*. at 24.
[39] *Id*.
[40] *See id*. at 25.
[41] *See id*.
[42] *See id*. at 45.

group focused on adult inpatient psychiatric services, "assuming that the hospital services would be coupled with other (expanded) community-based services," recommended "a hospital with no more than 50 beds."[43] Stakeholders involved in the API 2000 planning process confirm that the idea of a smaller psychiatric hospital was predicated on the expansion of community mental health services. DHSS and the Alaska Mental Health Board developed *A Shared Vision: The Alaska Mental Health Strategic Plan for the 90s* "to provide the community-based planning options to complement the facility-based planning involved in API 2000."[44]

The forensic work group "recommended that these assessment treatment services be provided in a hospital-type stand-alone facility or within an inpatient treatment module" with "approximately 30 beds."[45] The work group focused on older patients recommended 15 psychiatric assessment and stabilization beds at API and "20-30 long term nursing beds at or near to API for elderly patients with mental illness or organic brain syndromes."[46] The child and adolescent workgroup recommended a separate "cottage-style facility" at or near API with 25 beds.[47]

The recommendations from the various workgroups would have resulted in API having 95 adult beds and 25 beds for children and adolescents (a total of 120 beds), with expanded community-based mental health services (including DES and DET services in local hospitals) statewide. Yet, in 1992 there remained disagreement about the capacity needed at API moving into the future. At a stakeholder conference in June 1992, the "Alyeska Accord" was reached, laying out the agreed upon principles for the new facility:

- The purpose of API is to "provide tertiary care," defined as "acute, short-term care for those residents whose mental health needs cannot be provided for in the community, and/or longer-term care for those consumers with highly complex or high security needs;"

[43] *Id.* at 46 (*citing API 2000 Work Group Composite Report: Inpatient Recommendations*, DHSS (1990).
[44] *See id.* at 48.
[45] *Id.*
[46] *Id.*
[47] *Id.* at 47.

- "Financial support from the state to implement a community-based mental health system is necessary; otherwise the agreed-to bed need estimates . . . are unrealistic;"
- The new API should have 90 beds: 36 for adults, 18 for adolescents, 18 for geriatric patients, and 18 high security swing beds;
- "Crisis and 'secondary' (i.e. acute) care should be provided within regional centers to the extent possible;"
- Community mental health centers should utilize local evaluation and crisis treatment services before referring patients to API, a process "described as being implemented" by DHSS "with DE/T treatment beds in Sitka, Fairbanks, and Juneau" which were "seen as necessary to institute" the new API;
- Use of API as the primary acute psychiatric inpatient hospital for Anchorage "should be eliminated, and instead secure local Anchorage hospital(s)" should serve this need; and
- "Mobile expertise and consultation" (now referred to as mobile crisis units) "must be available."[48]

Forensic capacity was not discussed in the "Alyeska Accord," so the Alaska Mental Health Board recommended the addition of 24 forensic beds, for a total recommended capacity at the new API of 114 beds.[49]

During the revenue and budget retractions of the 1990s (when planning for API 2000 was occurring), the budget for API was reduced. From 1993-1997, the API budget decreased by $2.8m.[50] This resulted in a reduction in bed capacity from 160 beds in FY1993 to 79 beds by October 1994.[51] Capacity "to fully serve the State's individuals with mental illnesses was substantially reduced," so API prioritized admissions of patients who were "acutely suicidal, homicidal, or gravely disabled."[52] API was no longer able to provide treatment to patients who did not need "active psychiatric evaluation and treatment," patients with dementia requiring long-term

[48] *Id*. at 52-53 (*citing* "Alyeska Accord," E. Tucker and Alaska Mental Board (June, 1993).
[49] *See id*. at 53.
[50] *See id*. at 59.
[51] *See id*.
[52] *Id*. at 61.

assisted living, adolescents needing long-term residential psychiatric care, or individuals placed at API to prevent being jailed.[53]

The Hickel Administration proposed a capital project of $64.9m for a 114-bed hospital.[54] The Alaska Legislature appropriated $28.9m and capped the size of the new API at 72 beds.[55] The $28.9m capital appropriation was inclusive of the $6.1m previously provided for the API 2000 planning effort, reducing the amount available to build a new API to $22.8m.[56]

Planning for a smaller API continued, with eventual focus on a 72-bed hospital scenario and a 54-bed hospital scenario.[57] Complex negotiations and the intervention of the Alaska Mental Health Trust Authority ultimately resulted in the acquisition of a site for the new hospital.[58] A $15m grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) funded the implementation of the community mental health services needed to support the reduced inpatient capacity at API.[59] The SAMHSA-funded capacity building included the following new or expanded services in the Anchorage area:

- A "single point of entry" to provide emergency assessments, triage, crisis intervention, 23-hour observation, mobile response, and other services; Providence Hospital partnered with DHSS to create the Providence Psychiatric Emergency Room (PPER) in 2002 (a critical service that still operates today);
- Creation of supportive housing in the community for adults with serious mental illness who had been receiving long-term residential care at API;
- Creation of a wraparound treatment and support service for adults experiencing persistent serious mental illness discharged from API or referred by the Department of Corrections;

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[53] *Id.*
[54] *See id.* at 63.
[55] *See* HB 441 Senate Committee Substitute for House Finance Committee Substitute, Section 11 (enacted July 15, 1994).
[56] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 63.
[57] *See id.* at 64-103.
[58] *See id.* at 74-78.
[59] *See id.* at 83-88.

- Creation of an 8-12 bed crisis treatment center; and
- Enhancing dual diagnosis and detoxification capacity at Salvation Army Clitheroe Center.[60]

Efforts to expand DET services at local hospitals in Anchorage were not successful, so DHSS eventually chose the 72-bed scenario.[61] In 2001, the Alaska Legislature passed a bill to authorize an additional $16m in bonds for the API project, and the Alaska Mental Health Trust Authority authorized $3m.[62]

DHSS broke ground on the new API in March 2003.[63] The new 72-bed API facility opened in June 2005. With fewer beds available to serve patients statewide, API recommitted to the priorities for admission previously articulated in the "Alyeska Accord" in 1992 and again in 1994 when budget reductions led to reduced capacity in the old hospital.

Funding for API has remained relatively flat, with an operating budget of $32,227,200 in FY13 and an operating budget of $33,584,200 in FY19.[64] To incentivize hospital participation, state funding for DET services was increased in FY16.[65] While API is primarily funded by General Funds and federal Disproportionate Share Hospital funds, it is also of note that the General Fund funding for community behavioral health grants (which include grants for substance use disorder treatment services) decreased after FY13. A portion of that decrease, $8.5m between FY16 and FY19, is attributable to Medicaid Expansion.[66]

Since opening in 2005, API has had seven CEOs (or acting CEOs). Ron Adler served as CEO of API from 2003 until 2013. Ron Hale, who had served as chief operating officer for many years, stepped in as acting CEO until Dr. Melissa Ring was appointed CEO in 2014. Dr. Ring resigned

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[60] *See id.* at 89-101.
[61] *See id.* at 102.
[62] *See id.*
[63] *See id.* at 103.
[64] *See* Enacted Budget Reports prepared by the Legislative Finance Division for FY2013-FY2019.
[65] *See id.*
[66] *See* presentation and documents (Tab 5, slide 11) by Legislative Finance to the Senate Finance Subcommittee for Health and Social Services, February 11, 2019.

in 2016, and Gavin Carmichael became the acting CEO. Ron Hale was appointed the CEO of API in 2017. He was replaced by Duane Mayes in September 2018 after the release of the report on workplace safety at API. In December 2018, Mayes moved to another state department. Gavin Carmichael resumed the role of acting CEO until the end of February 2019. Wellpath Recovery Solutions is currently managing the hospital pursuant to the Commissioner's exercise of authority under AS 47.32.140 on January 30, 2019.[67]

Closing Harborview Hospital

The history of deinstitutionalization of adults experiencing intellectual and developmental disabilities (I/DD) in Alaska is relevant to the status of operations at API today. Prior to the 1964 earthquake, the Harborview Nursing Home in Valdez provided institution-based care for adults with significant I/DD.[68] After the earthquake, those patients were evacuated to the original API.[69] The patients remained at API until 1967, when the new Harborview Memorial Hospital opened in Valdez.[70] Harborview had capacity to serve up to 140 patients[71] until it closed in October 1997.[72] Those patients were transitioned to community-based services, funded primarily by Medicaid through the 1915(c) waiver program created in 1981.[73] Access to a wide array of community-based services was critical to the successful deinstitutionalization of this population in Alaska in the 1990s.

Since the closure of Harborview, there has not been an institutional level of care (known as an Intermediate Care Facility for Individuals with Developmental Disabilities or ICF/IDD) operating in Alaska. In 2009-2010, stakeholders and advocates raised concerns about individuals experiencing dementia or I/DD being held at API contrary to the requirements of the Americans

[67] This investigation was completed prior to Commissioner Crum's decision to contract with a private management company to oversee API operations, and does not involve any allegations or findings related to that decision.
[68] *See History of the Alaska Psychiatric Institute and the Community Mental Health/API Replacement Project – Evaluation Report* at 11, note 2.
[69] *See id.*
[70] *See id.*
[71] *See id.*
[72] *See* "Harborview Center," Valdez Museum Historical Archive.
[73] Congress passed legislation to allow states to request waivers of requirements of the Social Security Act, which governs the Medicaid program, in the Omnibus Budget Reconciliation Act (OBRA) of 1981 (PL 97-35).

with Disabilities Act, 42 USC §12101 *et seq.* (ADA) and the requirements laid out in *Olmstead v. L.C.* (1999) (*Olmstead*).[74] DHSS and the Alaska Mental Health Trust Authority hired WICHE to study the issue of Alaskans at risk of institutionalization due to challenging behaviors.[75] In 2010, WICHE reported that:

> Alaska's current system of care does not include the appropriate continuum and array of services for individuals with cognitive disabilities and complex behaviors. Because of this, many of these individuals are served by the Alaska Psychiatric Institute (API), where they languish in an unnecessarily restrictive environment for extended periods of time, or they are inappropriately held in places such as jails and emergency rooms.[76]

WICHE noted that the State risked costly litigation related to ADA and *Olmstead* violations, "continued inappropriate use of jails, corrections and emergency rooms," detrimental effects from "co-mingling individuals with cognitive disabilities with large numbers of individuals, including those individuals with behavioral health disorders," and safety risks associated with not managing complex behaviors adequately.[77] WICHE also noted that (in 2010) "Alaska is experiencing an increase in these requests" for ICF/IDD placement, "with increasing difficulty accessing these services in other states" because in-state clients are given priority.[78]

DHSS and stakeholders, including the Alaska Mental Health Trust Authority and the Governor's Council on Disabilities and Special Education, worked with WICHE to develop the Complex Behaviors Collaborative (CBC). The CBC began operations in 2012. It was designed to bring specialist consultants and technical assistance together to assist providers and families serving Medicaid clients (children, adolescents, and adults) with I/DD, dementia, brain injury, or chronic mental illness who also exhibited aggressive, assaultive, or challenging behaviors that increased the risk for institutionalization. The CBC coordinates specialist consulting and technical assistance for a small number of clients each year, but does not fill the gaps in the continuum of care nor does it address the risks identified in 2010.

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[74] *See* discussion of Legal Authority below.
[75] *See Alaska Complex Behavior Collaborative Report*, prepared by WICHE for DHSS and the Alaska Mental Health Trust Authority (2010) at 3.
[76] *Id*.
[77] *Id*. at 22-23.
[78] *Id*. at 23.

The problems that API faces in 2019 are a continuation of those faced in the decades before the "new" hospital was opened in 2005. They arise as a result not just of what has happened and is happening inside API, but also as a result of all that happens and has happened in the statewide mental health system.

Legal Authority

State Law

AS 47.30.660(b)(1) directs DHSS to "administer a comprehensive program of services for persons with mental disorders . . . including inpatient and outpatient care and treatment and the procurement of services of specialists or other persons on a contractual or other basis." DHSS is further required to "designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders." AS 47.30.660(b)(4).

7 AAC 12.200 *et seq.* governs specialized hospitals like API. These regulations require that a physician is available to respond to an emergency at all times (7 AAC 12.210(c)(2)).

7 AAC 12.215 governs psychiatric hospitals. Minimum staffing is provided in 7 AAC 12.215(b):

- a physician to supervise medical services;
- a psychiatrist to supervise psychiatric services;
- one or more psychologists to provide psychology services;
- one or more social workers to provide social work services;
- to supervise nursing services, a registered nurse with a master's degree in psychiatric nursing or a bachelor's degree registered nurse with 2 years or experience in psychiatric nursing and 2 years of nursing administration experience; and
- "sufficient registered nursing personnel to give direct nursing care, and to plan, supervise, and coordinate care given by other mental health workers."

7 AAC 12.215(c) defines the minimum services that must be provided by a psychiatric hospital:

- psychological testing and counseling;
- assessment, screening and diagnostic services;
- individual psychotherapy;
- group therapy;
- family therapy; and
- therapeutic occupational and activity programs.

7 AAC 12.215(d)(5) expands upon these minimum services, requiring the psychiatric hospital to have policies and procedures that "provide organized therapeutic activities with consideration for the interests and needs of the patients."

7 AAC 12.215(d)(3) requires a psychiatric hospital to have policies and procedures that provide for each patient to have "a written treatment plan, developed with the patient's participation as far as practicable, which incorporates a comprehensive interdisciplinary approach based on the patient's medical, social, and psychiatric or psychological evaluations."

AS 47.30.825(d) provides that:

> A locked quiet room, or other form of physical restraint, may not be used, except as provided in this subsection, unless a patient is likely to physically harm self or others unless restrained. The form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored. Nothing in this section is intended to limit the right of staff to use a quiet room at the patient's request or with the patient's knowing concurrence when considered in the best interests of the patient. Patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good medical practice so indicates. Patients in a quiet room must be visited by a staff member at least once every hour and must be given adequate food and drink and access to bathroom facilities. At no time may a patient be kept in a quiet room or other form of physical restraint against the patient's will longer than necessary to accomplish the purposes set out in this subsection. All uses of a quiet room or other restraint shall be recorded in the

> patient's medical record, the information including but not limited to the reasons for its use, the duration of use, and the name of the authorizing staff member.

AS 47.30.915(11) defines "least restrictive alternative" as treatment conditions that:

> (A) are no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and
>
> (B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury.

AS 47.30.825(c) provides that "a patient who is capable of giving informed consent has the right to give and withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis as described in AS 47.30.838(a)(1)."

AS 47.30.838 controls the administration of crisis medications:

> (a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if
>
> > (1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person, as determined by a licensed physician or a registered or advanced practice registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition must be documented in the patient's medical record; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient; and
> >
> > (2) the medication is ordered by a licensed physician; the order
> >
> > > (A) may be written or oral and may be received by telephone, facsimile machine, or in person;
> > >
> > > (B) may include an initial dosage and may authorize additional, as needed, doses; if additional, as needed, doses are authorized, the order must specify the medication, the quantity of each authorized dose, the method of administering the medication, the maximum frequency of administration, the specific conditions under which the medication may be given, and the maximum amount of medication that may be administered to the patient in a 24-hour period;

> (C) is valid for only 24 hours and may be renewed by a physician for a total of 72 hours, including the initial 24 hours, only after a personal assessment of the patient's status and a determination that there is still a crisis situation as described in (1) of this subsection; upon renewal of an order under this subparagraph, the facts supporting the renewal shall be written into the patient's medical record.
>
> (b) When a patient is no longer in the crisis situation that led to the use of psychotropic medication without consent under (a) of this section, an appropriate health care professional shall discuss the crisis with the patient, including precursors to the crisis, in order to increase the patient's and the professional's understanding of the episode and to discuss prevention of future crises. The professional shall seek and consider the patient's recommendations for managing potential future crises.
>
> (c) If crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839.
>
> (d) An evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent if the patient is unable to give informed consent but has authorized the use of psychotropic medication in an advance health care directive properly executed under AS 13.52 or has authorized an agent or surrogate under AS 13.52 to consent to this form of treatment for the patient and the agent or surrogate does consent.

AS 47.30.840(8) provides patients with the right to be free of corporal punishment. This is relevant in evaluating whether brief manual restraint is being used to punish or change patient behavior – rather than to protect the patient or others from immediate "serious harm." AS 47.30.915(12) defines what "likely to cause serious harm" means – it is when a person:

> (A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm;
>
> (B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or
>
> (C) manifests a current intent to carry out plans of serious harm to that person's self or another.

State regulation also lays out the expectations for psychiatric hospitals' use of seclusion and restraint. These guidelines must include:

> (A) the location of a seclusion room which allows for direct supervision and observation by staff;
>
> (B) construction of a seclusion room which minimizes opportunity for concealment, escape, injury, or suicide, including locks and doors which open outwards;
>
> (C) recording in a patient's medical record the time the patient spent in seclusion or restraints;
>
> (D) visiting a patient who is in restraints or seclusion at least hourly, and providing the patient with adequate opportunity for exercise, access to bathroom facilities, and time out of restraints or seclusion;
>
> (E) limiting the use of restraints or seclusion to situations in which alternative means will not protect the patient or others from injury; and
>
> (F) when practicable, consultation with the patient regarding the patient's preference among available forms of adequate, medically advisable restraints, including medication.[79]

Federal Law

The ADA requires that individuals experiencing disabilities receive services in the most integrated (and therefore least restrictive) setting appropriate to their needs. In *Olmstead*, the U.S. Supreme Court held that offering only institution-based mental health services was a form of discrimination prohibited by the ADA.[80] *Olmstead* requires that public entities provide community-based services to people experiencing disabilities when (1) services are appropriate; (2) the consumers agree to or want community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.[81]

42 CFR §482.13(c) provides that patients have the right to receive care in a safe setting and to be free from all forms of abuse or harassment. 42 CFR §482.13(e)(2) provides that "restraint or

[79] 7 AAC 12.215(d)(7).
[80] *See* 527 U.S. 581 (1999).
[81] *Id.* at 587.

seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm." The type of restraint or seclusion must be the "least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm."[82]

42 CFR §482.13(e)(4) *et seq.* lays out the procedural and staff training requirements for use of restraint and seclusion. Under federal regulation, a "restraint" is defined as "any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely" or "a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition."[83] Seclusion is defined as "involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior."[84]

42 CFR §482.13(e) also provides patients the right to be free from corporal punishment and unnecessary restraint or seclusion:

> All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

[82] 42 CFR §482.13(e)(3).
[83] 42 CFR §482.13(e)(i).
[84] 42 CFR §482.13(e)(ii).

API Policy and Procedure

In addition to state and federal legal authority governing hospital operations, API has adopted specific policies and procedures relevant to the three allegations investigated. API adopted PRE-010-02.01, an ethics policy, in 2017. This policy creates additional patient rights, including:

> In every instance, services and technological care provided are based on safety, efficacy, efficiency, costs, known (documented) experience, availability, and the affect [sic] on the institution's ability to provide other needed services as well as the competence and qualifications of staff to provide the services/technology. PRE-010-02.01 Policy III. B.

PRE-010-02.01 establishes a procedure that requires all API staff to "treat all persons, and particularly the patients that API serves, with dignity, respect and courtesy." PRE-010-02.01 Procedure I. A. Further, API staff are expected to treat patients with dignity and respect:

> In all circumstances, we attempt to treat patients in a manner that gives reasonable thought and concern for each patient's age, gender identity and expression, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status. PRE-010-02.01 Procedure I. D.

API has adopted a code of ethics in its Policies and Procedures (PRE-010-02.02) which includes the following expectations of all employees:

- We promote individual choice and a person's right to be involved in decisions about treatment.
- The staff role is to support, teach, and guide through trusting and therapeutic relationships.
- We strive always to promote the welfare of those with whom we have contact in the course of our work, and to prevent any harm.
- We recognize the human need to feel worthwhile, to maintain maximum level of privacy, and to be treated with respect. We therefore approach each other politely, refraining from any language or behavior that would detract from human dignity.
- We are honest, straightforward, and fair in our dealings with others.
- To regard the health and safety of patients as the first consideration and thereby render each patient the full measure of professional skill, ability and experience.
- To always encourage patients to participate in the planning of their care.

- To expose, without fear or favor, illegal or unethical conduct of others who are providing patient care or services.
- To respect the rights, views, and positions of all other staff, regardless of their degrees, discipline status or duties.

PC-060-06 governs notification of patients' family or guardians in the case of an emergency, defined as "i.e. a serious illness, accident, or death" (PC-060-06 I. B.):

> When an emergency occurs with a patient . . . [API] will immediately contact family members, guardians, and/or significant others, including the Community Mental Health Center (CMHC) case managers, to inform them of the situation and, if indicated, to provide supportive interventions during the time of crisis.

PC-060-06 I. B. requires the social worker or nursing shift supervisor to contact "family members and others" when a patient emergency occurs. The policy does not define what a reasonable time is for delivering notice but contemplates giving notice after usual business hours. PC-060-06 I. F. requires that notice and interventions with patients' support networks be documented.

API also defines behavioral emergencies, citing the definition provided by the Joint Commission:

> A situation when a patient's behavior results in an imminent risk of the patient harming himself or herself or others, including staff, when less restrictive interventions have been ineffective or are not viable, and when safety issues require an immediate physical response to prevent harm. SC-030-02.01b.

SC-030-02.01 describes API policy on patient seclusion and/or restraint:

> It is the policy of the API to treat all patients in the least restrictive environment that is consistent with individualized requirements for treatment and safety.
>
> Any restriction of patient rights will be done in a manner which maintains the dignity, well-being, and safety of each patient.
>
> No restriction of rights may be used as a punishment or as a substitute for a less restrictive form of treatment or intervention, or as a convenience for the staff.
>
> Restriction of rights, such as the seclusion or restraint of a patient, is used only to prevent physical harm to the patient or others and only after other interventions have been tried without success. Seclusion should be tried before restraint.

API policy is further described in SC-030.02.01b:

> API is committed to providing the least restrictive environment that supports the safe and therapeutic treatment of patients; and in doing so, API allows the use of seclusion and restraint only in response to a clear and significant risk to the patient or others.
>
> API will actively work to mitigate the use of seclusion and restraint to patients. API staff will therapeutically engage patients with de-escalation techniques. When appropriate API staff will involve the patient's family, and/or other individuals identified by the patient, in collaborative strategies on how the use of these restrictive procedures can be avoided. API will provide education on seclusion and restraint use in the hospital.
>
> API recognizes the possible serious consequences for patients secluded and restrained. API is committed to on-going efforts to mitigate the use of these restrictive procedures through the continuous monitoring of their use, and efforts to improve therapeutic engagement with patients.

Procedures defined by SC-030-02.01 include a prohibition on punitive seclusion or restraint (SC-030-02.01 I. D.).

API defines "restraint," with the exact language from 42 CFR §482.13(e)(1)(i)(A) in SC-030.02.01b. Restraint on a gurney, wrist restraints, bed restraints, and other mechanical restraints are specifically identified as "restraints." Physical holds, including those to administer medication, are also specifically included.

API defines chemical restraint as "medication used to control behavior, or to restrict the patient's freedom of movement, which is not a standard treatment for the patient's medical or psychiatric condition."[85] This is similar to the definition in 42 CFR §482.13(e)(1)(i)(B). API has determined that:

> Chemical restraint is considered an inappropriate method of controlling behavior and is not the practice of API. Use of a medication is considered inappropriate if: (a) it is not a recognized treatment for the patient's mental disorder; or (b) the medication is administered excessively, such that it can be expected to produce sedation or limit the patient's ability to participate in the treatment process rather than treat symptoms of the mental disorder. SC-030-02.01b.

[85] SC-030-02.01b; *see also* INT-005-03.

API defines seclusion with language aligned with 42 CFR §482.13(e)(1)(i)(C): any "involuntary confinement of a patient alone in a room or an area" where the patient is "physically prevented from leaving the room or area."[86] The room/area can be locked or unlocked.[87]

Procedures for seclusion and restraint are defined in SC-030-02.01b. Only NAPPI (Non-Abusive Psychological and Physical Intervention) approved physical interventions or restraint techniques are permitted under SC-030.02.01b I. A. 3. Standing orders for seclusion or restraint are expressly prohibited by SC-030.02.01b I. A. 1., and patient behavioral plans cannot include seclusion or restraint as an intervention according to SC-030.02.01b I. A. 4.

Seclusion or restraint "will not be used as a means of coercion, as discipline or punishment, for the convenience of staff, as retaliation by staff, as a substitute for treatment or rehabilitation programming, as a replacement for adequate levels of staff, or used in a manner that causes undue physical discomfort or pain to the individual."[88] Further, "intentional misuse" of restraint or "handling of a patient with more force than reasonable" is required to be "reported as abuse" under SC-030-02.01b I. A. 9.

API has adopted specific procedures to help prevent the need to seclude or restrain patients. These include gathering information from patients and family members about ways to avoid seclusion and restraint, history of maltreatment or trauma, and the patients' own preferences for dealing with emergency situations. (*See* SC-030-02.01b II. A.). SC-030-02.01b II. A. requires that this information should be documented by the licensed independent practitioner (LIP), who is also expected to talk with the patient and family about API's policies and procedures for seclusion and restraint, and to ask the patient if they want family to be notified about incidents when the patient is subject to seclusion or restraint.

SC-030-02.01b II. B. requires nursing staff to "continually monitor patients for signs of escalation of emotional and behavioral dyscontrol." If a patient is agitated, the registered nurse is required to

[86] *Id*.
[87] *Id*.
[88] SC-030-02.01b I. A. 8.

"assess the situation and patient behaviors," and determine how staff will respond.[89] When "effective and appropriate," staff will use "less restrictive alternatives" such as verbal redirection, offer/use of voluntary crisis medications, time out, distractions, or de-escalation techniques.[90]

SC-03-02.01b III. describes the procedures for use of restraint and/or seclusion. These are mostly aligned with the processes required by 42 CFR §482.13(e).

Allegations of Violence Toward Patients

Allegation 1 - Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients from use of force by API staff.

Based upon a preponderance of the evidence, the Ombudsman finds the allegation that API does not reasonably protect patients from excessive or unnecessary use of force by staff to be **justified**.

Assistant Ombudsman Jennifer Christensen investigated a complaint that API staff had assaulted a patient and that API management had not followed policy and procedure in its response to the incident. The evidence we reviewed confirmed that in December 2017, a Psychiatric Nursing Assistant (PNA) assaulted a patient. API staff who were present and witnessed the incident failed to document the incident as required by API Policy LD-020-12, and failed to report the matter to API management as required by API Policy LD-020-13.[91] Those API staff also failed to report the incident to Adult Protective Services (APS) within 24 hours as required by AS 47.24.010.

Four days later, the patient reported the assault to an API psychiatrist during a therapy session. The psychiatrist reported the matter to the Safety Officer and filed an Unusual Occurrence Report

[89] SC-030-02.01b II. B.
[90] *Id*.
[91] API Policy HR-040-06 Standards of Conduct prohibits API employees from engaging in serious misconduct, which includes failure to report abuse or neglect of any patient per AS 47.17.010-020 and 47.24.010.

(UOR) as required by API policy. That same day, the Safety Officer notified APS and HCFLC of the incident as required by API Policy LD-020-13.[92]

The Safety Officer conducted an internal review of the incident, completing it in February 2018. The PNA continued working at API while API completed the internal investigation. The PNA was moved to a non-patient duty station, which reportedly restricted contact with patients. The Safety Officer concluded that the allegation of patient abuse (assault) was substantiated. The PNA was ultimately terminated from API after consultation with human resources staff.

The ombudsman investigation determined that API had not reported the assault of the patient to law enforcement as required by API policy and procedures. API policy requires that the CEO or designee notify the Anchorage Police Department when there is probable cause to believe a crime has occurred, including criminal physical assault or sexual abuse. Likewise, API policy requires that any victim of an assault receive support and assistance to contact law enforcement. There was inconclusive evidence of whether this occurred in this case. According to API, a staff psychologist asked the patient if he wanted to report the assault to the police, but he declined. There is nothing in the patient's clinical record provided by API documenting this interaction.

The ombudsman investigation found that API had not notified the patient's guardian of the assault as required by API policy. API did not notify the patient or his guardian of the outcome of their investigation, the substantiation of the allegation of patient abuse, or the action taken by the hospital in response, all of which are required under API policy.

API is required to report any employee listed under AS 47.24.010(a) who fails to report the abuse or neglect of a vulnerable adult to the Department of Law for prosecution. None of the staff who witnessed the incident reported it to APS, law enforcement, or API management. There is no evidence that API reported the employees to the Department of Law as required by AS 47.24.010(c).

[92] APS did not investigate the report of harm, but forwarded it to the Alaska State Ombudsman.

Based on review of the Alaska Board of Nursing's database of disciplinary actions taken in 2017 and 2018, as well as the professional licensing database, it also appears that API has not reported the PNA's termination to the Board as required by AS 08.68.333. API has a legal obligation to report when licensed staff are terminated for patient abuse or neglect.[93] Failure to report allegations of abuse or neglect of a patient may result in enforcement action against an entity licensed by HCFLC.

The Ombudsman met with the API Medical Director and Quality Assurance Manager on March 28, 2018 and recommended that a) API immediately make a report of the assault to Anchorage Police Department and b) send a letter to the (now former) patient and his guardian explaining that API investigated the incident, substantiated the allegation of patient abuse, and took appropriate corrective action. The Medical Director confirmed that both actions had been taken on March 30, 2018.

The Ombudsman reviewed an incident on July 4, 2018 during which a patient's clavicle was broken. That evening, multiple adolescent patients on the Chilkat Unit showed agitation, decompensation, or other behavioral dysfunction. Former CEO Ron Hale described it as a "riot"

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[93] AS 08.68.277 imposes a duty to report on employers of nurses and nursing aides:

> (a) An employer of a nurse licensed under this chapter or a nurse aide certified under this chapter practicing within the scope of that license or certification that discharges or suspends a nurse or nurse aide or conditions or restricts the practice of a nurse or nurse aide shall, within seven working days after the action, report to the board the name and address of the person and the reason for the action. An employer shall report to the board the name and address of a nurse or nurse aide who resigns while under investigation by the employer. The requirement of an employer to report under this section applies only to a discharge, suspension, or restriction of practice that is based on a ground allowing action by the board under AS 08.68.270 or 08.68.334 or for conduct prohibited under AS 08.68.340.

AS 47.05.055 imposes an additional duty upon DHSS (of which API is a part) to report substantiated allegations of abuse or neglect involving certified nurse aides employed in licensed facilities:

> (a) If the department has reason to believe that a certified nurse aide employed in a facility licensed by the department under AS 47.32 as a hospital or nursing home has committed abuse, neglect, or misappropriation of property in connection with the person's duties as a certified nurse aide at the facility, the department shall investigate the matter. The department shall conduct proceedings to determine whether a finding of abuse, neglect, or misappropriation of property should be made. These proceedings shall be conducted under AS 44.62.330. A finding under this subsection that a certified nurse aide has committed abuse, neglect, or misappropriation of property shall be reported by the department to the Board of Nursing.

planned by the patients when he spoke to the Ombudsman the following day. Several API staff responded to the crisis on the unit.

During this response, two PNAs put an adolescent male patient in a vertical manual restraint against the door, beginning at 7:03 p.m. (based on video recording of the incident). Vertical restraint is specifically prohibited by API Policy and Procedure SC-030-02.01b. I.A.5.e. The API Safety Officer reported that all staff had been notified three (3) weeks earlier that vertical restraints were prohibited.

During the vertical restraint, the patient's arm was torqued. One of the PNAs stepped away from the hold, to be replaced by another PNA. According to the video evidence reviewed by the Ombudsman, at 7:04 p.m., the patient screamed "you broke my f*****g collarbone." He screamed this same sentence three times in quick succession. His screams were loud enough to be heard over a female patient also screaming at staff to release her while they were attempting to restrain her on a gurney.

Despite the cries of pain, the PNAs maintained the vertical hold, holding the patient against the door for three more minutes. Then the patient was transferred to a gurney. Video evidence shows that the patient was not struggling during the transfer to or restraint on the gurney. He moved to the gurney independently and was calm but for his comments: "f**k" and "you broke my collarbone." The patient was restrained on the gurney for approximately four minutes based on restraint and seclusion documentation.

The patient was taken to seclusion (the Oak Room), where he was held for 63 minutes according to the restraint and seclusion documentation. The documentation notes that the patient continued to complain of pain while in the Oak Room, but he was not assessed for injury until 31 minutes after his clavicle was broken. This is noteworthy not just because API staff were on notice that the patient was injured from before the seclusion was initiated. API Policy and Procedure SC-030-02.01b III.B. requires that a registered nurse assess the patient for any physical injury "when a patient requires restraint or seclusion." AS 47.30.825(d) requires that "patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good

medical practice so indicates." This patient was not assessed for injury when he was placed in seclusion, despite the fact that he "yelled at" the attending nurse that his shoulder was injured, nor was he assessed at the first required 15-minute check. After the patient was finally assessed for injury, API arranged for him to be transported to the emergency room thirty minutes later. His medical chart indicates that he suffered a broken clavicle as a result of the restraint.

The Ombudsman found no evidence that any of the staff attending that code July 4, 2018 filed a report of harm as required by AS 47.17.020(a)(1).[94] The Safety Officer filed a report of harm with the Office of Children's Services (because the patient was a minor) and a report of staff misconduct on July 5, 2018.

How API responds to allegations of misuse of force by staff is a longstanding issue of concern, based on CMS surveys for the past three (3) years. After a survey visit on July 19, 2018, CMS made findings that API failed to complete process reviews for two episodes of restraint in June 2018. These incidents had been identified as circumstances involving possible patient maltreatment, but "process reviews of both events had not been completed by nursing administration and none of the involved staff had been interviewed and/or educated on possible patient maltreatment."[95] Surveyors also found that there were 16 cases of possible patient maltreatment from January 1-June 13, 2018, that had not been reviewed by API administration.[96]

After the August 31, 2017 survey, CMS made findings that API failed to adequately respond to the use of unnecessary force against patients. A PNA providing 1:1 observation of a patient experiencing significant intellectual/developmental disabilities responded to the patient's aggressive behavior "when the 'patient dropped the chair and fell to the floor" (and presumably was no longer posing a threat to the PNA) by charging and "tackling the patient to the ground,"

[94] "Practitioners of the healing arts" are required by law, when in the course of their professional duties they have reasonable cause to suspect that a child has suffered harm as a result of child abuse or neglect, to make a report to the Office of Children's Services. AS 47.17.020.
[95] CMS Statement of Deficiencies and API Plan of Correction (July 19, 2018 survey), produced by API on August 28, 2018, at 21.
[96] *See id.*

pulling the patient's hair, and placing the patient "briefly in a choke hold."[97] API substantiated the allegation that the PNA used unnecessary force against the patient, but the PNA was permitted to return to work a month later with the requirement that the PNA meet "regularly with his/her clinical supervisor" for at least 30 minutes/session for the next year.[98] API provided five clinical supervision sessions over the next two months, and no more.[99]

CMS surveyors made similar findings related to the lack of response to possible patient maltreatment in 2016. After the May 16-18, 2016 survey visit, surveyors found that API failed to properly respond to patient reports of abuse or misuse of force. One incident stemmed from a patient's allegations that she was tackled to the ground by a PNA.[100] Surveyors found that there was no contemporaneous documentation (UOR) of the incident described by the patient, though a UOR was completed "9 days after" the patient filed a grievance about the incident.[101] The written response to the patient stated that API had conducted a "thorough investigation of the incident" and was "taking corrective action."[102] The Safety Officer reported that, as a result of the investigation of the incident, additional training was required for the PNA involved.[103] However, surveyors noted that the PNA involved "had not completed any extra training yet related to the patient grievance."[104]

Another incident noted by the surveyors in May 2016 stemmed from a patient grievance. This time a patient raised concerns that another patient was subjected to unnecessary restraint and the improper use of force (bending the patient's fingers back at the wrist).[105] Staff documentation (UOR) of the incident stated that the patient "began a verbal altercation" with another patient, then "screamed and tried to hit" the PNA.[106] A brief manual restraint was "administered as reported

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[97] Amended API Plan of Correction for CMS Survey Completed August 31, 2017 produced by API on August 28, 2018, at 13.
[98] *Id.*
[99] *See id.* at 13-14.
[100] CMS API Statement of Deficiencies and Plan of Correction (July 15, 2016), produced by API August 3, 2018, at 14.
[101] *Id.*
[102] *Id.*
[103] *See id.* at 15.
[104] *Id.* at 14-15.
[105] *See id.* at 20-21.
[106] *Id.* at 20.

by" the PNA – indicating that the author of the UOR did not observe the incident.[107] Documentation further stated that the patient was restrained to a gurney and transported to the Oak Room where the patient was held in seclusion for 96 minutes.[108] The Safety Officer reported that video evidence of the incident was "more aligned" with the allegations in the patient grievance than staff documentation, but the investigation was still ongoing at the time of the survey visit.[109] API reported that the PNA at issue "continued to work during the still ongoing investigation and there was no process to ensure patients were protected during the investigation."[110]

Allegation 2: Unreasonable: API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients due to violence by other patients.

Based upon a preponderance of the evidence, the Ombudsman finds the allegation that API does not reasonably protect patients from violence by other patients to be **justified**.

After the May 30-31, 2018 survey visit, CMS made the finding that API failed to protect a patient from being sexually assaulted by another patient (an incident discussed at greater length herein); and API reported the assault to law enforcement but not HCFLC as required by API policy and procedure.[111] The Ombudsman reviewed video and documentary evidence related to this incident.

In the spring of 2018, a male patient raped a female patient. Under Alaska law, sexual penetration of another person known to be "mentally incapable" is sexual assault in the second degree – a class B felony.[112] The male patient had a history of arrest (in 2012) and conviction (in 2014) for assault. He pleaded no contest to the crime of indecent exposure four days before the sexual assault.

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[107] *Id.*
[108] *See id.*
[109] *Id.* at 21.
[110] *Id.*
[111] *See* CMS Statement of Deficiencies and API Plan of Correction (May 31, 2018), produced by API on August 3, 2018, at 6-8.
[112] AS 11.41.420(a)(3).

The patient was raped in the TV room of a unit at API – a room in full view of the nurses' counter, video surveillance, and staff when working on the unit floor. The Ombudsman observed the incident on the video recording shared by API on September 6, 2018. The video from the unit showed only one PNA on the nursing counter. That PNA moved away or out of sight several times in the hour leading up to the assault. API reported that staff had been recently advised by email about the expectations to maintain constant coverage at the nursing counter.

The video showed the PNA leaving the nursing counter, at which point the male patient was observed checking through the TV room window to determine if anyone was on the floor or at the counter watching. A 360-degree review of the video showed no staff visible on the unit floor at that time. The male patient proceeded to remove the female patient's pants and to sexually assault her in full view of the nurses' counter and video surveillance.

API staff did not respond to the sexual assault until another patient, who had entered the room and saw what was happening, immediately reported it to a PNA. The PNA went to the door of the TV room (without entering the room) and is heard on the video saying "Stop – we don't do that here." She did not approach either patient or identify what was occurring as sexual assault.

The male patient was permitted to return to his room. Later documentation reflects that staff permitted him to shower, compromising evidence of the sexual assault. The video showed API staff watching the still half-dressed female patient, who was left alone in the TV room. No observable effort was made by API staff to exclude other patients from the TV room or from the window where she could be seen half-dressed. The female patient continued to sit, half dressed and in full view of others, alone in the TV room. Several minutes passed before staff approached the patient who had been sexually assaulted and directed her to dress herself.

The female patient dressed and followed direction to leave the TV room. She came out, walked slowly to the nurses' counter then wandered alone down the hall. There is no evidence that API staff checked her for injury (physical or psychological) in the minutes after the assault.

According to the former Quality Assurance Manager, the female patient was taken for a forensic sexual assault exam after the assault. There is evidence that API staff called Anchorage Police Department, who responded and took both patients for further interviews. API placed the patients on separate units when they returned from the police interviews. A Nursing Communication Report states that the female patient "withdrew her complaint" of rape while at the hospital for the exam, while also noting that the patient was "unable to engage in linear/logical exchange."

A psychiatrist's medical notes of the encounter with the female patient two days after the sexual assault characterized the incident as her being "sexually involved with another client." The repeated characterization in the documentation of the event and in both patients' medical records as "sexual activity" rather than statutory rape is relevant, given the manner in which API responded to this and subsequent events. The same psychiatrist noted that the day after the sexual assault, the female patient displayed increasing agitation and became assaultive toward staff – but there is no discussion in his notes of whether he or other staff attempted to determine whether these behaviors were the result of the recent trauma or her ongoing symptomology.

The male patient was discharged three days after sexually assaulting the female patient. According to his medical records, an API social worker contacted his guardian the day of discharge to notify them of his imminent release from the hospital. The social worker documented explaining the "incident over the weekend," his "current presentation and the [licensed independent practitioner's] belief that the patient does not meet criteria for a court commitment with medication."

The Ombudsman requested personnel files for the staff on duty when the patient was raped. The staff assigned to the nurses' counter – who left it unattended – had nothing in his personnel file related to the sexual assault of the female patient. There is no evidence that API took personnel action related to this incident in his personnel file. The Ombudsman requested to see the supervisory file for the employee. API could not locate a supervisory file for him, which may be due in part to the separation/termination of the previous Director and Assistant Director of Nursing in the summer of 2018.

The Ombudsman reviewed the personnel file for the API staff member assigned to locater duties (checking patients every 15 minutes) when the sexual assault occurred. There is no evidence that API took personnel action related to this incident in his personnel file. There is evidence that the API took personnel action for similar allegations of poor performance in the past.

The sexual assault of this patient was due to a lack of required attention and observation by API staff. Despite the severity of that incident and the extensive root cause analysis performed by API, another patient was sexually assaulted on January 28, 2019 – allegedly because staff failed to perform their duties. This assault was not reported to APS, which is how the Ombudsman typically learns about these incidents. Instead, a member of API staff alerted the Ombudsman to the incident.

When interviewed on February 1, 2019, the Quality Assurance Manager reported that an adult male patient on close 1:1 supervision groped a female adult over her clothing on January 28, 2019. An internal review of the incident was underway. The Quality Assurance Manager noted that "a week before" this incident, API staff had received training on how to handle these kinds of incidents, but staff in this instance failed to follow that training.

The Quality Assurance Manager explained that the initial evidence showed that the PNA assigned 1:1 to the patient had ceased arm's length supervision of the patient, allowing the patient the opportunity to approach and assault the female patient. The unit supervisor, a nurse, did not report the incident according to API policy and procedure. The nursing shift supervisor reported the assault to the Anchorage Police Department. The Quality Assurance Manager explained that the male patient was charged with a misdemeanor but not arrested. API moved that patient to a vacant unit and assigned him to 3:1 supervision. HCFLC was notified of the event. The PNA and unit supervisor were both placed on administrative leave pending the outcome of the internal investigation.

The Quality Assurance Manager also stated that he had, with support from API and DHSS leadership, established a video station where live feed from the hospital is now being watched 24/7. Any incidents – especially those that can be averted with timely intervention – are reported

to the nurse shift supervisor so that resources can be deployed to assist staff and patients more quickly.

The Ombudsman advised the Quality Assurance Manager that none of the health practitioners who observed or had knowledge of the assault had made a report of harm as required by AS 47.24.010. She provided the information needed to make a report to APS, and he filed a report of harm with APS that day.

Understanding that an internal investigation is being conducted, the Ombudsman still notes this recent incident because a patient was harmed again as a result of either insufficient or inattentive staffing – and that any remedial actions taken by API since the rape of a patient in 2018 did not prevent a similar (though less violent) assault on another patient in January.

The Ombudsman is also concerned that some staff display a permissive attitude toward patient on patient assaults. This observation is corroborated by records API provided showing other incidents of patients being harmed by other patients with little to no response from staff. For example, on January 2, 2018, a patient reported that another patient had been assaulted by a third patient, and the victim had an injury to his eye. Staff observed a hematoma on victim's eye. The patient who had been assaulted confirmed he had been hit but could not identify the assailant. The assault occurred in the TV room (which is in full view of the nurses' counter), but there is no documentation that staff witnessed or acted upon the assault when it occurred. There is no documentation showing that accused assailant was interviewed, or that any effort was taken to determine what triggered his behavior (so that it could be avoided in the future).

Allegation 3: Inappropriate Use of Seclusion and Restraint

Based upon a preponderance of the evidence, the Ombudsman finds the allegation that API does not consistently comply with AS 47.30.825(d) or 42 CFR §482.13(e) in the use of seclusion and restraint to be **justified**.

Episodes of Seclusion and Restraint Reviewed

The Ombudsman reviewed documentation related to incidents of seclusion and restraint from January to September 2018, as well as data provided by API Quality Assurance. She reviewed all the findings made by CMS from 2016 through July 2018. She reviewed video evidence and conducted interviews with staff regarding general and specific incidents of seclusion and/or restraint.

After the May 2018 survey visit, CMS made the following findings related to how API restrained and/or secluded patients:

- API failed to provide trauma-informed care to a female patient during an episode of restraint, administration of IM medication, and seclusion;[113]
- API failed to provide personal privacy to a female patient, attended by four male PNAs, or to treat the patient with dignity during the administration of IM medications during a seclusion event;[114] and
- API left a patient in the Oak Room after she had urinated on herself and the bed, refusing to allow her to use the bathroom upon request (instead providing a "bed pad" for her to use), failing to provide clean clothing for over an hour, and failing to provide an opportunity for the patient to wash her hands prior to eating the sack lunch provided.[115]

After a survey visit on July 19, 2018, CMS made findings related to two episodes of seclusion of the same patient. That patient had been diagnosed with intellectual disabilities as well as a serious mental illness.[116] In the first episode, on July 15, 2018, the patient was subject to a brief manual hold because she reportedly was "disruptive to the milieu."[117] Staff then placed her in seclusion,

[113] *See* CMS Statement of Deficiencies and API Plan of Correction (May 31, 2018), produced by API on August 3, 2018, at 5-6.
[114] *See id.*
[115] *See id.* at 3-4.
[116] *See* CMS Statement of Deficiencies and API Plan of Correction (July 19, 2018 survey), produced by API on August 28, 2018, at 30.
[117] *Id.*

according to the documentation, "for the welfare of the other patients on the unit."[118] She was held in seclusion for 124 minutes. Surveyors reviewed video of the incident and found no evidence that the patient was "likely to physically harm self or others unless restrained," as required by AS 47.30.825(d). Surveyors noted that the patient entered the Oak Room calmly and sat down on the bed, at which point the door was locked and the two-hour seclusion initiated.[119] Surveyors also noted that the video showed that the patient was calm throughout the seclusion, despite API's documentation that the patient was yelling, screaming, or beating the door.[120] Surveyors noted that the times of the documentation of the patient's allegedly uncontrolled behavior in the Oak Room were during periods of time where video showed that a) the patient was calm and b) API staff were not actually monitoring the patient.[121] Surveyors noted that the patient was not actively monitored for 42 minutes of the two-hour seclusion.[122]

The same patient was subject to seclusion again on July 16, 2018. Surveyors described the documentation justifying the brief manual restraint and seclusion of the patient, as well as the video record of the incident.[123] They are not aligned. Again, the video showed that the patient was placed in a brief manual restraint and walked to the Oak Room, where the patient calmly entered and sat down on the bed.[124] The door was locked, and the patient was left in seclusion for 41 minutes.[125]

After the July 19, 2018 survey, CMS made additional findings related to the brief manual restraint and seclusion of a different patient who had been diagnosed with autism (no psychiatric diagnosis was noted by the surveyors).[126] The documentation of the incident reported that the patient was slamming doors and refusing staff direction, necessitating restraint and seclusion.[127] Surveyors

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[118] *Id.*
[119] *See id.*
[120] *See id.*at 50-51.
[121] *See id.*at 51. The Ombudsman notes that falsifying business records is a class C felony in Alaska under AS 11.46.630.
[122] *See id.*at 50-51.
[123] *See* CMS Statement of Deficiencies and API Plan of Correction (July 19, 2018 survey) at 31.
[124] *See id.*
[125] *See id.*
[126] *See id.* at 32.
[127] *See id.*

noted that video of the incident showed that the patient was taken, unassisted, from their bedroom to the Oak Room, when the patient sat down on the bed unprompted.[128] The patient was left in the locked Oak Room for 40 minutes.[129]

These episodes of seclusion – without evidence of an immediate risk of harm to the patient or others – clearly violate 42 CFR §482.13(e), which provides: "All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff."

After the August 31, 2017 survey, CMS made findings that API failed to ensure that staff followed seclusion policy and procedure during an April 12, 2017 incident. A PNA escorted a patient to the Oak Room for a period of seclusion, without the required physician's order or assessment for seclusion.[130] While there was some evidence that this incident was labeled a "time out" (voluntary seclusion), subsequent events clearly indicated it was an involuntary seclusion of the patient.[131]

Once at the Oak Room, the PNA proceeded to prevent the patient from leaving by pushing them back into the room twice (rather than shutting and locking the door).[132] The PNA refused the patient access to bathroom facilities, resulting in the patient urinating in the Oak Room.[133] Later, a nurse ordered the patient to clean up the urine of the floor with a towel.[134] No gloves or other protection were provided, and no assistance was provided; neither was the patient provided with clean clothes.[135]

Two months later, API sent a letter of warning to the PNA involved, stating that the allegation of patient abuse was substantiated and directing the PNA to "attend a 1:1 session with the API Safety officer to review the differences between and protocols relating to time outs and seclusions; and

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[128] *See id.*
[129] *See id.*
[130] *See* Amended API Plan of Correction for CMS 2017 at 11-12.
[131] *See id.*
[132] *See id.* at 12.
[133] *See id.*
[134] *See id.* at 14.
[135] *See id.*

continue with your weekly sessions with your clinical supervisor for the next six months."[136] API failed to provide the weekly clinical supervision to the PNA after the substantiated abuse and unauthorized – and unlawful – restraint and seclusion of the patient.[137]

API reported to surveyors that it had provided a letter of instruction to the nurse, who resigned after the incident.[138] However, surveyors found no documentation of the letter of instruction – and surveyors observed the nurse working as a clinical lead on an API unit during their site visit on August 16, 2017 – four (4) months after the incident API reported had prompted the nurse's resignation.[139]

The Ombudsman reviewed all the seclusion and restraint documentation provided by API for January-September 2018. She was particularly struck by a long episode of restraint in the Oak Room, implemented at the request of a patient who determined that he could not stop hurting himself, even with staff support and coaching. According to Director of Psychology, this young patient is one of the API patients admitted for long periods of time due to intellectual/developmental disabilities rather than suicidality or psychiatric disorder. API documentation showed that, on April 19, 2018, staff attempted to keep the patient safe with less restrictive means, including time out, medication, and coaching, but were unsuccessful. The patient requested to be restrained in the Oak Room. Once restrained and isolated, the patient laid calmly. There is significant documentation from multiple members of staff who engaged with the patient in the Oak Room, ensuring that they were comfortable and that, as soon as they were ready, they could be released from the restraints. The patient was allowed to determine when they were able to control their self-injurious behaviors and was released immediately upon request hours later. This is one of the several examples identified in this investigation of how API staff can handle very challenging patients – and can support patients in directing their own care – with compassion and care.

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[136] *See id.* at 12.
[137] *See id.*
[138] *See id.* at 14.
[139] *See id.*

The Ombudsman also identified an episode of what appears to be unlawful chemical restraint. Chemical restraint is expressly prohibited by API policy. Even so, on May 31, 2018 API staff subjected an adolescent patient to involuntary IM medications rather than permitting the patient to voluntarily take oral crisis medication or attempting seclusion without medication. The Ombudsman reviewed video of this incident, provided by API on September 6, 2018. Staff documentation of the incident was that the patient was agitated, "cussing" at peers on the unit, and threatening someone with "let's go b***h!" Documentation provided by API states that verbal interventions and redirection were attempted.

The video and audio recording showed that several API staff surrounded the patient in the hall. It did not reflect how staff were using less restrictive means (required by law and policy) to help the patient regulate his behavior. The patient attempted to move past the staff around him, purportedly toward another patient. He was placed in a vertical hold (which is, as previously discussed, a prohibited form of restraint) against the wall.

API documentation provided justification for the restraint: the patient was "verbally abusive toward staff, threatened staff then charged him with a pen raised overhead." In the video of the minutes leading up to the restraint, there is no evidence of the patient charging staff with a pen. API documentation stated the purpose of the restraint was to assist the patient to "move to safe place." Staff walked the patient to the seclusion room, where video shows him entering the room willingly and sitting on the bed.

A few minutes later, four male staff and a female nurse enter the room, crowding around the patient in the small Oak Room. The Nurse Shift Supervisor stood at the door. API documentation stated that a voluntary time out was offered but video and audio from the Oak Room does not show staff explaining to the patient whether this is a voluntary time out or seclusion. The presence of so many staff indicates there is no choice available to the patient.

A nurse stated "I have medication for you. It's a shot. We need you to lay down." The patient responded, "I'm calm" (indicating that he is in control of himself and does not need crisis medications). He is observed sitting on the bed, not exhibiting any behavior that posed a risk to

himself or others. The four male staff stand at the corners of the bed on which the patient was sitting. The patient said again, "I'm calm." Someone in the room responded, "No." The patient is clearly heard on the video, saying "I'll take the medication," indicating he will take crisis medication by mouth. An unidentified API staff responded: "Because you attacked someone, you have to take the shots." API staff unequivocally connected the IM medications as a consequence for the patient's behavior, rather than a therapeutic intervention.

The patient replied: "The shots hurt. You don't know what it feels like." One staff member tried to reassure him but the patient was visibly upset. Still, the patient remained on the bed and was physically calm. A PNA then put his hands on the patient and pushed him onto his stomach. The other three male staff joined the restraint at the shoulders and legs. The nurse administered the IM medications. API staff then left the adolescent patient on the bed, crying and alone. A few minutes later, staff returned and took him back to the unit.

In this instance, API imposed a prohibited form of physical restraint upon a patient who was clearly not posing a risk to his own safety or the safety of others, then administered involuntary IM medications as a consequence for earlier behavior. There is no clear therapeutic value to API's actions, and a clearly observable negative consequence – and trauma – to the patient. Thus, the Ombudsman finds that the actions of API staff in this incident violated federal regulation and API policy, both of which define "chemical restraint" as "a drug or medication when it is used as a restriction to manage the patient's behavior . . .and is not a standard treatment or dosage for the patient's condition."[140] API policy further holds that "chemical restraint is considered an inappropriate method of controlling behavior and is not the practice of API."[141]

Equally concerning is that the Nursing Shift Supervisor observed this incident and did not intervene when the patient agreed to take oral crisis medication. She did not intervene when API staff described the IM medications as a consequence for the patient's behavior. She completed the UOR (incident report) and supervisor review within minutes of each other. She also completed the

[140] 42 CFR §482.13(e)(1)(i)(B)
[141] SC-030-02.01b.

required staff debrief form, on which she wrote that the patient was "given opportunity to make healthy choices" and that was how API staff applied "trauma informed care concepts before and during the incident." Based upon review of video and audio evidence, this is an inaccurate description of what occurred.

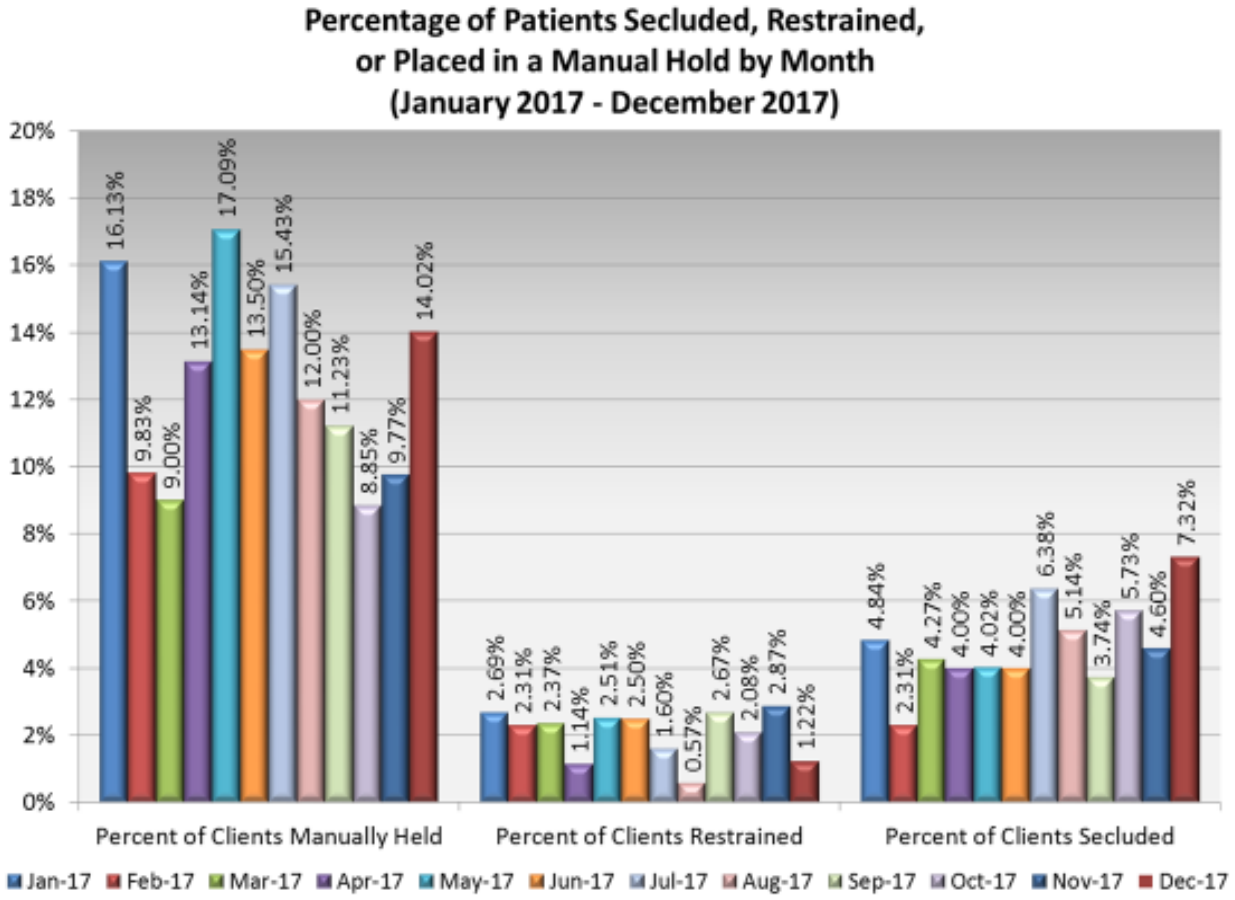
API Performance Improvement Data, 2017-2018

API provided data on the use of restraint and seclusion in 2017. The rate of patient restraint (with mechanical restraints) remained consistently low (.87-4.4/1,000 inpatient days).[142] The rate of manual holds ranged from 15.81/1,000 inpatient days to 56.31/1,000 inpatient days.[143] The rate of seclusion ranged from 2.79/1,000 inpatient days to 15.99/1,000 inpatient days.[144]

API also quantified use of seclusion and restraint by percentage of patients affected (Table 1). Between 8.85% and 17.09% of patients were subject to a manual hold in any given month in 2017.[145] Between .05% and 2.87% of patients were restrained each month.[146] In 2017, between 2.31% and 7.32% of patients were subject to seclusion each month.[147]

[142] *See* API Performance Indicator Data, Quality Assurance and Performance Improvement, January 18, 2018 at slide 11.
[143] *See id.*
[144] *See id.*
[145] *See id.*at slide 12.
[146] *See id.*
[147] *See id.*

Table 1: Percentage of Patients Subject to Manual Holds, Seclusion and Restraint – 2017

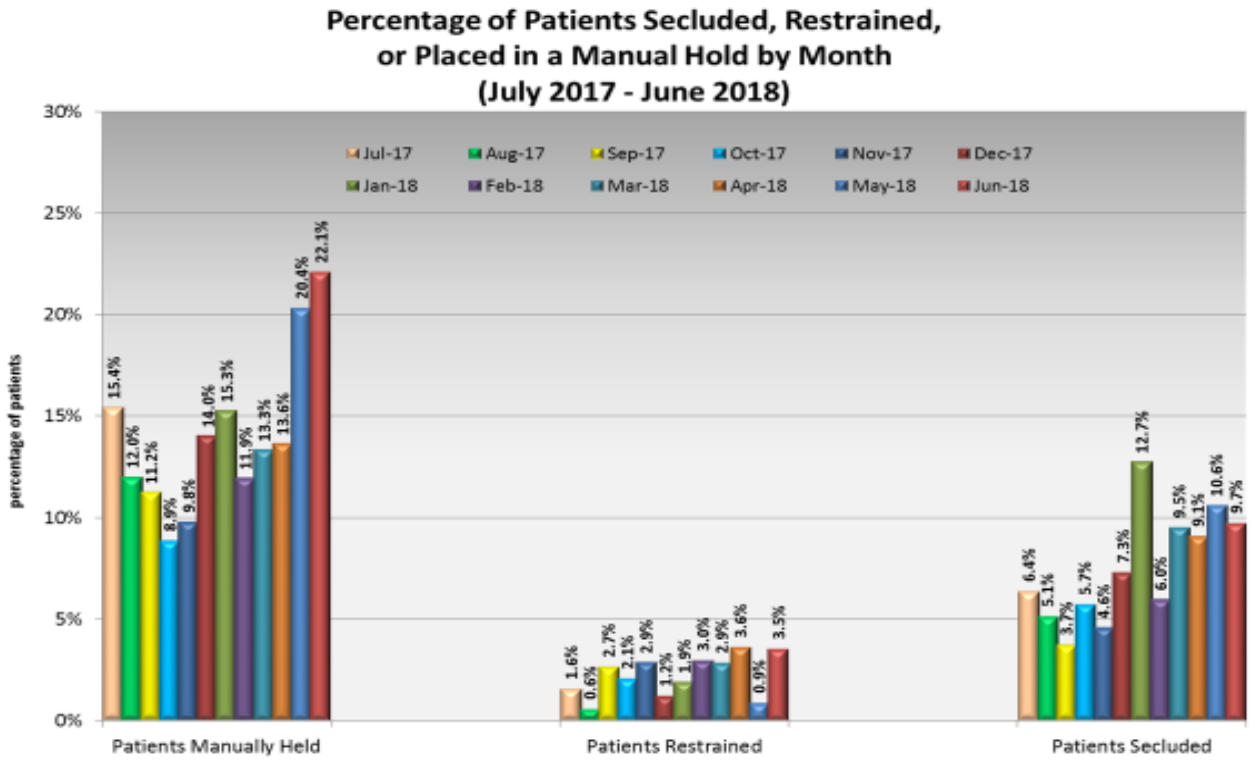


Source: API Performance Indicator Data, Quality Assurance and Performance Improvement, January 18, 2018.

In the first six months of 2018, between 11.9% and **22.1%** of patients were subject to manual hold.[148] **One in five patients were subject to manual hold in May and June 2018.**[149]

[148] *See* API Performance Indicator Data, Quality Assurance and Performance Improvement, July 19, 2018 at slide 14.
[149] *See id.*

Table 2: Percentage of Patients Subject to Manual Holds, Seclusion and Restraint – FY18



Source: API Performance Indicator Data, Quality Assurance and Performance Improvement, July 19, 2018

The average percentage of patients restrained in the first six months of 2018 was 62% higher than the preceding six months (2.6% compared to 1.6%).[150] **The average percentage of patients subject to seclusion in the first six months of 2018 was 75% higher than the preceding six months (9.6% compared to 5.46%).**[151] API data shows that, in FY 18, the average duration for seclusions exceeded 1 hour in five (5) of the twelve months – exceeding 2 hours in November 2017 and 3 hours March 2018.[152]

Given the variability in the rates of patient hours in restraint and seclusion, the Ombudsman reviewed additional data sets provided by API to identify contributing factors. This included

[150] *See id.*
[151] *See id.*
[152] *See id.* at slide 16.

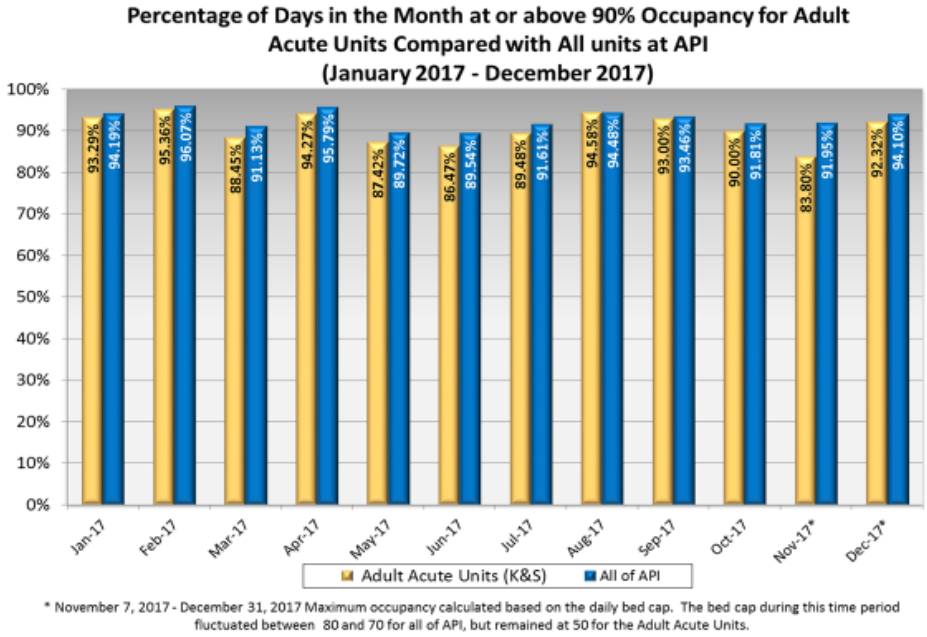
hospital census data for 2017 (Table 4). According to API, the adult acute units (Katmai and Susitna) were at or above 90% capacity for at least 83% of days each month in 2017.[153] The entire hospital was at or above 90% capacity for at least 89% of days each month in 2017.[154]

Census pressures continued in FY18 (July 2017-June 2018), with the entire hospital running at or above 90% capacity for ten (10) months of the year.[155] API was completely full (100% occupancy) in August 2017, April 2018, and May 2018.[156] It was 90-99% full for four (4) other months in FY18.[157] A series of unit closures occurred in FY18 as API addressed structural safety concerns and staffing shortages, so this data is adjusted to reflect actual capacity (rather than 80 beds).

There is not a clear correlation between the months when API was at or above 90% capacity for the highest number of days and the utilization of seclusion and restraint. In fact, the months when API had the most patients (February, April, August, and September) were months with lower utilization of manual holds, restraint and seclusion.

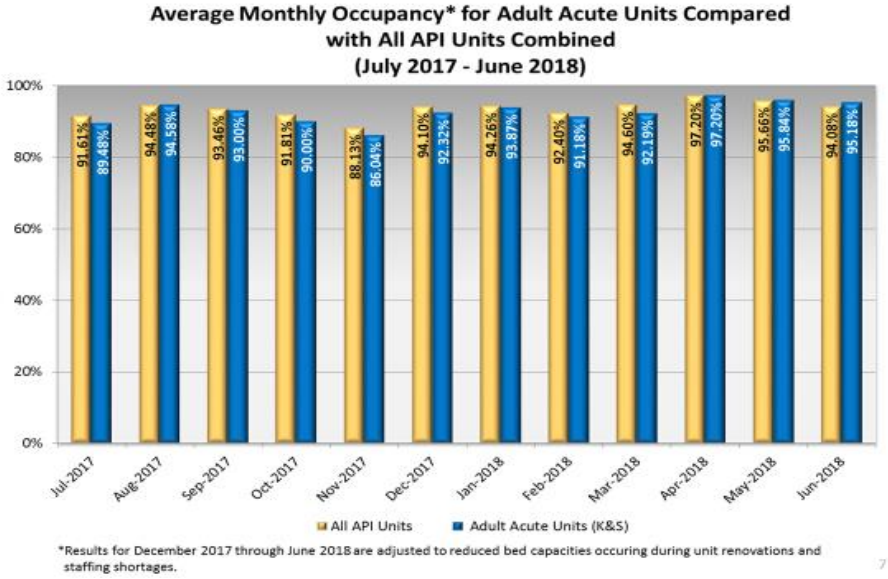
[153] *See* API Performance Indicator Data, Quality Assurance and Performance Improvement, January 18, 2018 at slide 11.
[154] *See id.*
[155] *See* API Performance Indicator Data, Quality Assurance and Performance Improvement, July 19, 2018 at slide 7.
[156] *See id.* at slide 8.
[157] *See id.*

Table 3: Percentage of Days at or above 90% Capacity at API – 2017



Source: API Performance Indicator Data, Quality Assurance and Performance Improvement, January 18, 2018.

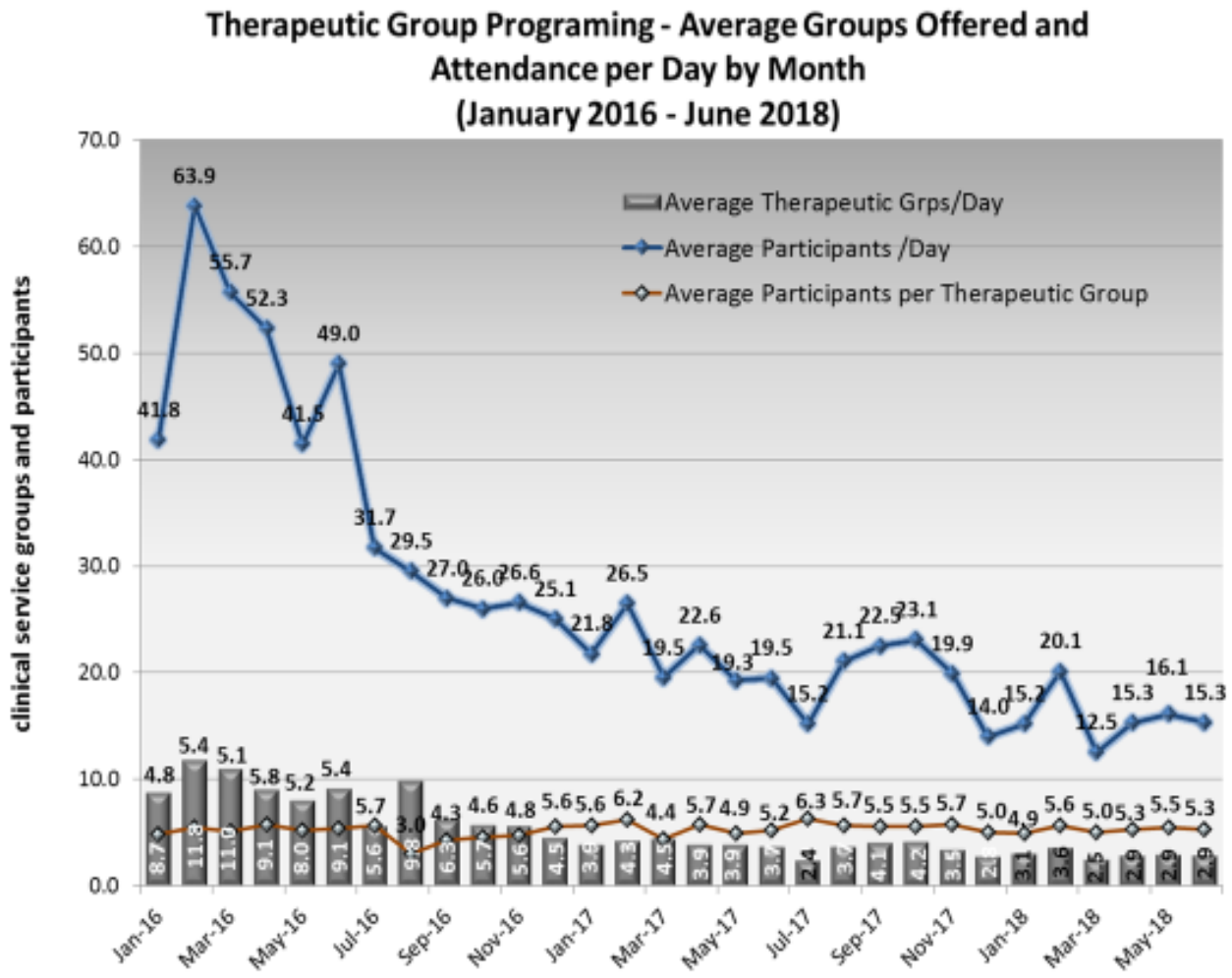
Table 4: Average Monthly Occupancy, Adult Units API – FY18



Source: API Performance Indicator Data, Quality Assurance and Performance Improvement, July 19, 2018.

The Ombudsman also reviewed treatment participation data for 2016-2018 (Table 5). **According to API, the average number of treatment groups dropped from 11.8 groups per day in February 2016 to 2.9 groups per day in June 2018.**[158] Adolescent patients participated in therapeutic programming at lower levels in 2017 than 2016.[159]

Table 5: Therapeutic Group Programs Offered, Attended 2016-2018



Source: API Performance Indicator Data, Quality Assurance and Performance Improvement, July 19, 2018.

[158] *See id.* at slide 25.
[159] *See* API Performance Indicator Data, January 18, 2018 at slide 14.

The same trend occurred for forensic patients[160] and acute adult patients during that time.[161] Total patient participation in therapeutic programs at API declined 76% between February 2016 and June 2018.[162] This can be attributed in part to the 75% reduction in therapeutic groups offered.

API provided data from 2017-2018 that show that less than 70% of patient treatment plans documented patient involvement (which is required by federal regulation and API policy).[163] Less than 70% of treatment plans were reviewed according to schedule in 2017.[164] That rate improved somewhat in the first half of 2018, with over 70% of treatment plans being reviewed on schedule in three of those six months.[165]

Patients are less likely to engage in treatment without some buy-in or investment in the process. Treatment regimens are less likely to be effective when they are not updated or modified based on patients' progress (or lack thereof). This increases the likelihood that patients will experience symptoms or demonstrate behaviors that require restraint or seclusion, and thus contributes to the utilization rates.[166]

The Ombudsman notes that close supervision of patients, with a goal of intervening earlier when patient behaviors begin to escalate and supporting patients to self-regulate, can help reduce the need for restraint or seclusion. Close observation is required whenever API determines a patient "requires additional observation and monitoring due to potential harm to that patient or others."[167] The close observation status scale (COSS) includes first degree, where the patient is checked every 15 minutes and their status is noted by "locater" staff. Second degree COSS is 1:1 observation, with staff (a PNA) in the same room with the patient, usually within arm's length, and maintaining

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[160] *See id.* at slide 15.
[161] *See id.* at slide at 16.
[162] *See* API Performance Indicator Data, Quality Assurance and Performance Improvement, July 19, 2018 at slide 25.
[163] *See* API Performance Indicator Data, January 18, 2018 at slide 31; *see also* API Performance Indicator Data, July 19, 2018 at slide 34.
[164] *See id.* at slide 32.
[165] *See* API Performance Indicator Data, July 19, 2018 at slide 35.
[166] *See also* "Non-Confidential Public Report of Alaska Psychiatric Institute Investigation," Williams Evans, J.D. (September 7, 2018) at 6 for discussion of how lack of programming affects safety at API.
[167] API Policy and Procedure PC-060-14.

continuous visual focus on the patient. Third degree COSS is the highest level of observation, with 2:1 staffing within arm's length of the patient and continuous visual monitoring.

API staff must remain focused and engaged (as appropriate) with the COSS patient to whom they are assigned. They may not eat, read, or engage in other distractions while assigned to a COSS patient.[168] Given the intensity of COSS, staff may not be assigned to 1:1 observation of a patient for more than two hours at a time, and may not be assigned to 2:1 observation for more than one hour at a time.[169]

This level of patient care requires additional staff, or overutilization of overtime. In FY17, there were more than 150 1:1 COSS patient days in six out of the 12 months.[170] That year, 1,879 additional staff days were required to cover the needs of 1:1 and 2:1 patient observation. [171] In FY18, the number of patient days per month of 1:1 COSS observation ranged from 125-226.[172] The number of patient days per month of 2:1 COSS observation ranged from 0-31.[173] The acuity of these patients resulted in API needing 2,327 additional staff days in FY18 to meet the demand for close observation.[174]

Additional Areas of Concern Identified by the Investigation

After the May 2018 survey visit, CMS found that API failed to follow law and policy related to patients' treatment plans of care:

[168] *See id.* at section V.
[169] *Id.*
[170] *See* API Performance Indicator Data, January 18, 2018 at slide 24.
[171] *See id.* at slide 25.
[172] *See API Performance Indicator Data,* API Quality Assurance and Performance Improvement (July 19, 2018) at slide 11.
[173] *See id.*
[174] *See id.* at slide 13.

- API did not ensure that patients' right to participate in their treatment plan of care was provided by denying one patient the opportunity to participate in his treatment plan meetings on three separate occasions in the month since his admission;[175]
- API failed to modify a patient's treatment plan of care after an episode of seclusion or to record the episode of seclusion according to API policy and procedure; neither had API reviewed the patient's treatment plan of care in the three weeks prior to the survey;[176]
- API failed to ensure that an interdisciplinary team developed complete and current care plans for half of the patients sampled; for one patient surveyed, failed to complete an initial treatment plan (required within 24 hours of admission) until six (6) days later; for another patient, the March 2018 treatment plan of care was not updated despite identifying in May 2018 that the patient may have been a victim of sexual assault (information warranting a review and possible modification of the treatment plan under API policy and procedure);[177] and
- API failed to document whether or how they implemented a patient's individual behavior plan and failed to document whether the plan was discussed at the patient's treatment team meetings; PNAs providing care for the patient reported either having no knowledge of the patient's individual behavior plan or not reviewing the individual behavior plan posted in the nurse's station.[178]

After the August 31, 2017 survey, CMS made findings that API failed to ensure that a patient received care in a safe setting (failing to prevent a patient's significant self-injury):

- API staff neglected a patient on COSS, not checking the patient every 15 minutes as required; the "time missed between checks ranged from 16 minutes up to 83 minutes;"[179]

[175] *See* CMS Statement of Deficiencies and API Plan of Correction (May 31, 2018) at 4-5.
[176] *See id.* at 9.
[177] *See id.* at 10-11.
[178] *See id.* at 13-14.
[179] Amended API Plan of Correction for CMS 2017 at 11.

- As a result of not checking the patient every 15 minutes, the patient had the opportunity to inflict serious self-injury, including a "punctured or lacerated basilic vein"[180] and possible head injury;[181]
- API staff falsified the patient safety checklist (which showed 15 minute checks throughout the shift), including the time of the incident; review of the video evidence did not show the documented safety checks;
- API did not report the incident to HCFLC as required by law and policy; and
- API did not take any disciplinary, remedial, or correction action with the staff involved in the incident.[182]

After the August 31, 2017 survey, CMS also made findings that API failed to meet federal requirements for staffing and delivery of care, specifically the requirement to ensure adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide necessary nursing care to all patients:

- API documented that several PNAs and nurses had worked "20 hours to 135 hours beyond their regularly scheduled hours in the approximate 2-week time period" reviewed in July 2017;[183]
- API Safety Committee Meeting minutes documented concern over staff sleeping at work, long (14-16 hour) shifts, and inadequate staff (3 nurses and 3 PNAs) on the units; and
- Interviews with a physician, PNAs and nursing staff corroborated the large amounts of overtime worked, attributing it to lack of staff and staff absences due to injuries at work.[184]

[180] The basilic vein is in the upper arm.
[181] *See* Amended API Plan of Correction for CMS 2017 at 11.
[182] *See id.*
[183] *Id.* at 19.
[184] *See id.*

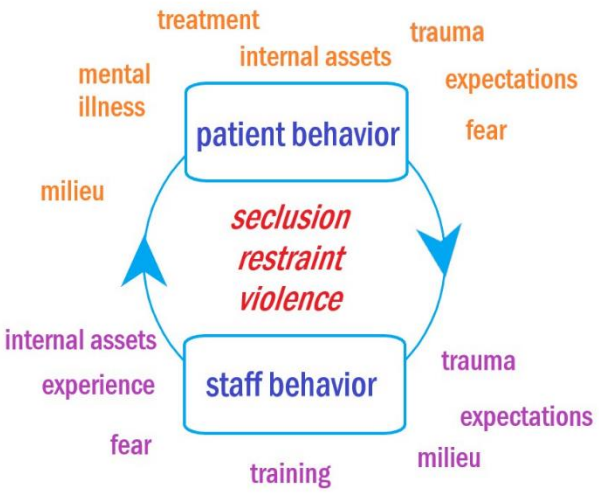
Staff and Patient Behaviors

The Ombudsman seeks to provide recommendations that are based in evidence and research, to address areas in need of improvement identified in an investigation. In this particular investigation, the recommendations being made focus on the underlying issues at API that gave rise to the complaints. At the heart of the allegations related to patient safety and utilization of restraint and seclusion are the behaviors of patients and API staff, and how they respond to each other. Patients admitted to API are in crisis and either pose a danger to themselves or others or are gravely disabled. They have no choice in their admission, and they cannot discharge themselves when they want. This sort of situation very reasonably creates fear, confusion, and anxiety for patients.

Consistent themes in interviews of staff, from PNA to CEO, included feelings of fear, distrust, conflict, and suspicion. Many staff described elements of power and control dynamics in how API is managed and how hospital services are delivered. Perceptions of patients' actions as well as those of peers and managers were filtered through these lenses.

There is a feedback loop between patients and staff which contributes to the incidence of violence and utilization of seclusion and restraint at API. Patients bring with them their internal and external assets and deficits, the traumas they have experienced, and the symptoms and behaviors associated with their psychiatric disorders. Staff bring their own internal and external assets and deficits. They, too, have experienced trauma – whether inside or outside the hospital. Their behaviors are as important to this equation as those of the patients. Based on the Ombudsman's extensive

Diagram of Patient – Staff Feedback Loop



interviews with API staff, as well as the inquiry made by Bill Evans related to workplace safety, this feedback loop is a significant contributor to the allegations investigated.

API staff described for the Ombudsman the hospital in which they want to work. It is a hospital that provides an environment that is supportive of healing: calm, safe, not crowded, permeated with the feeling that people are there to help and not to hurt. Staff are well trained, mentored, and offered continuing professional development. Hospital leadership are also well trained in the art of management. It is a hospital where there is open dialogue and respect for patients and staff. There are common expectations and consistent consequences for staff and for patients. It is a hospital that is recognized for the critical services it provides to Alaskans.

Recommendations

The Ombudsman recognizes that DHSS and API have been engaged in a long-standing effort to improve services and capacity at the hospital. Every CMS survey cited herein has resulted in a Plan of Correction with specific strategies and benchmarks for resolving the problems. Additional funding for nurses' salaries, bonuses, and positions was requested for FY19, and the Legislature appropriated those funds. API has attempted to address the acute needs of its I/DD and dementia patients by engaging a specialist and bringing on university students to augment therapeutic capacity. By June 2018, the API CEO and senior management were meeting every Thursday with former Commissioner Valerie Davidson and DHSS leadership to identify, implement, and monitor ways to address admission waitlists, program and treatment deficiencies, ongoing oversight investigations, and personnel issues.[185]

DHSS contracted with Joint Commission Resources to provide technical assistance to help API achieve compliance with state and federal requirements.[186] DHSS also attempted to negotiate a System Improvement Agreement with CMS in August 2018, to provide API with time to resolve

[185] *See* Interview of Deputy Commissioner Karen Forrest, August 29, 2018.
[186] *See id.*

deficiencies. Governor Walker and Commissioner Davidson used their emergency powers to deploy resources and recruit community partners to resolve some of API's deficiencies through the DHSS Emergency Operations Center on October 13, 2018.

The Alaska Legislature appropriated an additional $3.1m in FY19 to expand nursing capacity at API. The Walker Administration approved creation of 82 additional clinical and support positions proposed by API (discussed below) in October 2018. Additional funding (an estimated $7.06m) for these positions, needed to resolve the deficiencies found during the CMS Surveys in 2017-2018, was not included in the FY19 supplemental budget proposal made by the current Administration on January 28, 2019.

Leadership changes in quick succession in 2018-2019 have not resulted in immediate improvements, and deficiencies continue to be documented. On February 8, 2019, Commissioner Adam Crum announced that a private health care organization, Wellpath Recovery Solutions, had been awarded a contract to "provide administrative leadership" of API "with continued oversight from the state."[187]

The Ombudsman offers recommendations to assist API to strengthen staff and patient assets to minimize challenging and violent behaviors, and thereby reduce incidents of violence toward patients and the need to use restraint and seclusion. All of the proposed recommendations discussed below were the subject of the consultation with API leaders on January 25, 2019. The comments and information provided by participants in the consultation, as well as DHSS's response to the preliminary report of the investigation, have been incorporated into the final recommendations.

[187] February 8, 2019 Press Release from DHSS.

Recommendation 1: DHSS, if it continues to accept court-ordered patients whose primary diagnosis is anything other than suicidality or a serious mental illness (i.e. a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities), should place those patients in an intermediate care facility for intellectual/developmental disabilities (ICF/IDD) or a facility that provides dementia care, and not API.

On April 20, 2018, then director of the Division of Behavioral Health Randall Burns reported that API capacity was 58 beds. Of the patients at API on that day, six (6) were older than 65 and experiencing dementia and five (5) were adolescents experiencing intellectual/developmental disabilities. He explained that these 11 patients – 19% of the hospital capacity – were only at API because there were no community services to which to discharge them.[188] He also commented on the fact that these patients had much longer lengths of stay than patients committed for psychiatric crises.[189]

On September 5, 2018, the Director of Nursing reviewed the patient census with the Ombudsman. Of patients admitted to API on that day, 20% did not have a primary diagnosis of serious mental illness. Some experienced significant and gravely disabling I/DD and some experienced dementia. In reality, API has even less capacity to treat patients experiencing psychiatric crises than the hospital bed count – because 20% of the beds are being used for long-term residential care for patients needing ICF/IDD or dementia care services.

Based on staff interviews as well as the Ombudsman's review of seclusion and restraint records and UORs for 2018, I/DD and dementia patients accounted for a large proportion of incidents of violence toward self or others, and utilization of seclusion and restraint. These patients require higher levels of supervision (COSS, 1:1, etc.), putting strain on staff. These patients are also in

[188] *See* Interview of Randall Burns, April 20, 2018.

[189] The Ombudsman does not have jurisdiction over judicial officers or their decisions, so the issue of mentally ill patients being released by the courts despite not having access to community services after discharge while courts order patients experiencing dementia or intellectual/developmental disabilities to remain at API because there are no community-based services is one to be resolved by DHSS, the Alaska Court System, and the Alaska Legislature.

need of specialized treatment and rehabilitative services outside the expertise and experience of API staff.

API has attempted to complement internal professional capacity by working with an Applied Behavioral Analyst (ABA) and ABA students from the University of Alaska. All reports are that these efforts have – with much time and effort – made a significant difference for the few patients receiving ABA services. However, this limited addition to API clinical capacity has not reduced the stress that serving this population puts on the hospital, nor does it address the legal ramifications of serving these populations in such a restrictive and clinically inappropriate setting.

API is a psychiatric hospital, not an ICF/IDD facility. API should not be serving patients who do not experience suicidality or a serious mental illness or psychiatric disorder. The current situation at API runs contrary to the ADA and the requirements laid out in *Olmstead.*

DHSS has attempted to expand community capacity to serve individuals with challenging behaviors resulting from I/DD and dementia. In addition to the Complex Behaviors Collaborative (discussed above), the Division of Behavioral Health partnered with HOPE Community Resources in Anchorage to create community placement for four (4) API patients diagnosed with dementia. However, there remain individuals who require facility-based care (as evident from the percentage of long-term patients at API who experience I/DD or dementia).

In the short term, DHSS should identify appropriate services (whether in-state or out-of-state) for API patients who do not have a psychiatric disorder that is responsive to the psychiatric treatment that API provides – and transfer patients to the least restrictive clinically appropriate service setting. DHSS, with its counsel from the Department of Law, should convene the Court System and other stakeholders in the involuntary treatment legal process (i.e. Title 47), with the goal of reducing commitments of Alaskans experiencing intellectual/developmental disabilities, brain injuries, and dementias to API.

In the long-term, DHSS should convene providers, consumers and families, advocates, and other stakeholders in the systems serving Alaskans experiencing intellectual/developmental disabilities,

brain injuries, and dementias to discuss how the State of Alaska will provide clinically appropriate and consumer-centered services in the least restrictive settings possible – while recognizing that there is a documented need for some sort of facility-based care staffed with appropriately credentialed and experienced clinicians and staff to provide services for patients with assaultive, aggressive, and challenging behaviors.

DHSS accepted this recommendation in part, responding:

> API will convene with the DHSS leadership to discuss the development of community-based less restrictive placement options for individuals with IDD/ dementia and related disorders, who currently do not experience an acute psychiatric crisis and do not carry a psychiatric diagnosis. API will request this collaboration to begin no later than June, 2019 and is a part of the implementation of the 1115 Waiver currently accepted by the Centers for Medicaid and Medicare Services (CMS) and in the planning stages.
>
> The importance of placing the aforementioned patients in the clinical setting, which promotes the therapeutic benefits of addressing the specific needs of these individuals, will constitute the focal point of the initiative. API will expeditiously review the Ombudsman recommended community-based treatment setting options with DHSS, and will seek the most clinically appropriate means to provide needed care to patients currently at API, while ensuring they are not at risk to self or others, and will arrange respective transfers of these patients.
>
> In addition to the 1115 Waiver mentioned above, the Department is also:
>
> > 1) establishing a higher level of capacity at the Alaska Pioneer Homes in order to serve elderly individuals in a more appropriate setting;
> >
> > 2) the Department has contracted with individual Assisted Living Homes (ALH) where appropriate to provide the least restrictive placement option; and
> >
> > 3) in July of 2019 the Department will be putting out a Request for Letters of Interest (RFLOI) to ALH providers who can provide care to high acuity patients and see what the level of interest and capacity is in the state that could be rolled into the second phase of the 1115 Waiver process to stand up that level of service. This last effort would include those populations mentioned in this recommendation, which typically have had little access to appropriate care within the state.[190]

[190] DHSS Response at 2.

Recommendation 2: API should identify and implement tools and resources to reduce the incidence of challenging patient behaviors and/or promote self-regulation.[191]

Research supports the observations of API staff that patients are often stressed and act out when there is nothing to occupy their attention – or nothing to help distract them from whatever is inciting their challenging behaviors. Possible additions to the API toolbox, collected from staff and through review of evidence in the investigation include the following.

Physical Activity

API has long struggled, and continues to struggle, to maintain clinical and nursing staff necessary to serve patients effectively. This means that, when API experiences staff shortages, patients lose out on time in the gym and in the yards because there is simply not staff to supervise patients outside of the unit. Structured physical activity, whether playing basketball in the gym, dancing, or playing outside can help patients expend energy and improve their physical and mental well-being.

During the consultation, participants agreed that physical activity is an important component to the treatment and services API provides. They also explained that, due to past injuries to staff from sports activities (and the subsequent Workers Compensation claims), API instituted a policy that staff could not play basketball or other sports with patients. Some participants admitted to ignoring this "policy," citing the value of interactions with patients when they are able to play together. Staff also noted that the sound system in the gym has been broken for a long while.

After the consultation, the Ombudsman reviewed the API policies and procedures and found no written policy forbidding staff from engaging with patients during these kinds of activities. API Policy EOC-110 Accident Prevention Practices provides that staff should "walk, do not run" and

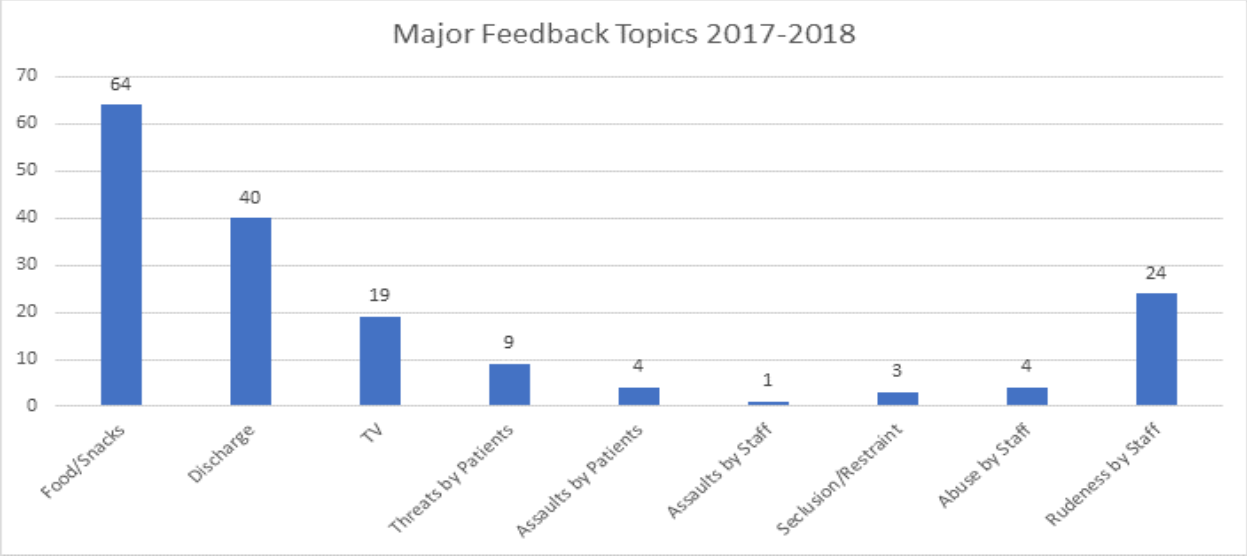
[191] For additional research on preventing and mitigating patient aggression, *see e.g. Strategies to De-Escalate Aggressive Behavior in Psychiatric Patients*, RTI-UNC Evidence-Based Practice Center for the Agency for Healthcare Research and Quality (July 2016); *Predictors of Effective De-Escalation in Acute Inpatient Psychiatric Settings*, Lavelle, M. et al., JOUR. OF CLINICAL NURSING 25, 2180-2188; *Developing an Evidence-Based Practice for Psychiatric Nursing*, Buccheri, R. et al., USF Nursing and Health Professions Faculty Research and Publications (May 2010).

described personal injury prevention regarding ladders and lifting. It does not prohibit staff from participating in sports, gym, or exercise activities. API management should provide clear and uniform guidance to all staff regarding the expectations and limitations on engaging with patients in organized or free play.

Snacks

Review of patient grievance and comments for January 2017-September 2018 shows what issues are most important to patients. Access to food and snacks was the major complaint – and appears in many UORs as a factor in the behaviors that escalate to violence or an episode of restraint or seclusion.

Table 6: Patient Grievance Issues, 2017-2018



Source: Patient Grievance Logs 2017-2018, Recovery Support Services

Healthy (and tasty) snacks, including subsistence/traditional foods and beverages, could help staff redirect, distract, calm, or otherwise occupy patients. The Ombudsman understands that some patients may have medical conditions that warrant restrictions on food choices, but there are still ways to provide snacks to patients when they want them.

Life Skills and Other Activities

There is clinical benefit to cooking, music, sewing, crafting, cultural, and other sorts of activities. These sorts of activities provide an opportunity for building rapport and relationships between patients and staff, which in turn can enhance staff's ability to identify, engage, and de-escalate behaviors with patients before they reach a crisis point. There is also the benefit of giving patients an activity to focus on, rather than wandering the units or engaging unproductively with peers and staff. This will require expanding recreational and occupational therapy capacity and providing PNA staff with training and resources to co-lead activities.

Sensory Aids

There is a great deal of stimuli on the units at API. As discussed above, units are often near or at capacity. Patient behaviors can be loud, distracting, invasive, or upsetting to others. The Ombudsman observed (directly and through video) that even positive interactions between patients and staff can be at a loud volume. There can be a lot of movement on the units as patients and staff come and go. This level of stimuli can be difficult for patients to manage, adding to the anxiety of being committed to a psychiatric hospital.

The Alaska Department of Corrections has reported success from the use of a sensory room to assist prisoners experiencing serious mental illness to self-regulate and de-escalate their behaviors.[192] This could be an additional form of voluntary "time-out" that averts the need for restraint or locked seclusion, and potentially even crisis medication. During the investigation, nursing staff suggested issuing noise cancelling headphones to patients, with an assortment of music options, to help patients control the stimuli around them. At the consultation, the participants

[192] Spring Creek Correctional Center has created a sensory room, The Oasis, with nature murals, soft furnishings, soothing sounds, etc. Inmates can request to use the sensory room when they feel anxious or stressed, with the goal that time away from the stimuli in the prison will help them return to a calmer state. A similar room has been implemented at Anchorage Correctional Center. *See* "Experimental Oasis Project Gives Inmates 'Something Different in Prison,'" Anne Hillman, Alaska Public Media (September 28, 2017).

advised that some headphones are available on the units – but not enough for all patients. Participants also reported success using weighted blankets to help patients self-regulate.

Behavioral Plans

A consistent theme in interviews with nursing staff and mental health clinical staff was dissatisfaction with behavioral plans, particularly those designed according to applied behavioral analysis principles. Several floor and supervisory staff admitted that behavioral plans are often ignored (or staff are unaware of them), and that there are no consequences for failing to follow or implement them.

If API intends to continue to use behavioral plans to help patients self-regulate and to help staff de-escalate challenging behaviors, there must be consensus as to their purpose, value, and implementation. Several API staff expressed interest in using incentives to encourage patients to engage in safe and positive behaviors. Some units may already be using something like this. API should consider whether to fully implement a reward system, and if so, should establish guidelines so that it is consistently applied across shifts and units.

Working with natural leaders among the PNA and nursing staff who can effectively communicate this policy – and show successful outcomes when they are implemented – will help improve the effectiveness of behavioral plans (and thereby reduce incidence of violence, restraint, and seclusion). Human Resources, the Director of Nursing, and unit supervisors should work together to establish clear and consistently applied consequences for deliberate failure to follow behavioral plans.

Quality Assurance/Performance Improvement Data and Health Analytics

API can better identify contributors to challenging patient behaviors by collecting, analyzing, and actively using its data from UORs and patient treatment data, including treatment outcomes. This wealth of information can help API see:

- what triggers challenging behaviors in the general patient population;
- what triggers challenging behaviors in specific units;
- what triggers challenging behaviors in specific patients;
- what interventions most effectively prevent challenging behaviors;
- what interventions most effectively redirect challenging behaviors;
- what interventions most effectively de-escalate challenging behaviors;
- what patient behaviors do staff struggle to address effectively;
- what staff behaviors do patients respond negatively to;
- what staff behaviors do patients respond positively to; and
- other performance measures.

This data should not be used to evaluate individual staff or to modify individual patient treatment plans. Instead, it should be used to guide Hospital Education offerings, milieu management decisions, deployment of treatment resources, and other strategic decisions by API leadership and managers.

DHSS accepted this recommendation in part. DHSS committed to reviewing the API wellness program and re-examining programming modules "with the goal of enhancing patients' engagement and participation."[193] DHSS also explained that "the model being currently introduced by Wellpath includes six hours of active therapy a day per patient."[194] DHSS stated that API would "re-evaluate its processes" for providing snacks and subsistence foods for patients.[195]

DHSS agreed that "regularly scheduled recreational and occupational therapy activities" will benefit patients, and cited Wellpath's 6-hour active treatment model as an example of how API was addressing the lack of treatment services and activities for patients.[196] DHSS agreed to expand

[193] DHSS Response at 2.
[194] *Id*.
[195] *Id*.
[196] *Id*.

access to sensory aids for patients, and committed API leadership to "research the option of creating a 'Quiet Room.'"[197]

DHSS reported that API staff will receive training on the development and implementation of behavioral plans, and ensure a "clear understanding as to the plans' value and purpose" by April 5, 2019.[198] Further, "Human resources and Nursing Leadership will set clear expectations for staff regarding adherence to the policy and process" for using behavioral plans with patients.[199]

DHSS reported that it is currently revising its Quality Assurance/Performance Improvement Program, and will be incorporating "enhancement of data collection and reporting practices."[200]

Recommendation 3: API should place patients in units by acuity, and staff accordingly.

API has attempted to organize its patient populations so that services can be delivered more effectively, while also complying with appropriate laws and regulations. The Chilkat Unit (10 beds) serves adolescents. The Susitna (26 beds) and Katmai (24 beds) units serve adults. The Taku Unit (10 beds) is dedicated to forensic patients, who are primarily patients committed to API by a criminal court for evaluation and restoration or who have been transferred to API from the Department of Corrections. The Denali Unit (10 beds) is currently closed, though is used when patients need to be sequestered.

Currently, patients of varying diagnoses, symptomology, and acuity are housed together on the adult and adolescent units. This makes it difficult to tailor group active treatment options to the patients' needs. It also makes it difficult to staff the units with PNAs and nurses who have the training, skills, and aptitudes best suited to serving specific patients. This means that a large unit with many highly acute patients, or a small unit with even just one or two highly acute patients, can see higher incidence of violence and use of restraint and seclusion.

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[197] *Id*.at 3.
[198] *Id*.
[199] *Id*.
[200] *Id*.

At the consultation, API staff explored how this might work. The current hospital structure would allow for placing patients based on immediate acute need versus the need for intermediate care. They cautioned, however, that staff assigned to work high acuity units for long periods of time could experience greater burnout. There was also discussion of organizing therapeutic services off the units, so that patients could be included based on their treatment needs rather than unit assignment.

In 2018, DHSS contracted with Anchorage architect Steve Fishback to provide options for expanding API, which currently lacks capacity to meet the psychiatric inpatient hospital demand of Alaska's current population. This provides an opportunity to explore ways to serve patients better by creating physical space that allows for placing patients in units by acuity. API staff observed that smaller units are usually less chaotic, and patients respond better to staff and programming in less crowded milieus.

DHSS accepted this recommendation:

> API leadership will pursue the Ombudsman's recommendation and along with the Clinical Leadership of the hospital, will re-evaluate the acuity level of all current patients with the goal of developing alternative appropriate treatment and housing milieu for each patient within the hospital as well as to be able to sustain this milieu for the newly admitted patients. Wellpath is assisting API in exploring better means of utilizing smaller spaces within the hospital or to develop a plan for a possible re-design of the existing spaces.[201]

Recommendation 4: API should revise its policies and practices regarding Unusual Occurrence Reports (UOR), and the associated medical chart documentation, to ensure that the information is effectively recorded and used to inform patient treatment plans; management, coaching, and training of staff; milieu management; resource allocations; and broader hospital management decisions.

[201] DHSS Response at 3.

Having reviewed the UORs completed from January-September 2018, the Ombudsman has identified practice and policy areas warranting attention. UORs are often not completed by staff with first-hand knowledge of the facts of the incident. This limits the value of the information in the report. API should consider requiring the staff who took lead on the code, or who was directly involved in the incident, to complete the UOR. (This may not be appropriate if the staff was also a victim of violence by the patient.)

It was not infrequent that the Nurse Shift Supervisor on duty completed the UOR and then conducted the supervisor review within minutes of the underlying incident report. This avoids third-party review of the incident, especially if the Nursing Shift Supervisor leads (or simply fills out the form for) a staff debrief after the incident. API should require the Nursing Shift Supervisor, or the Nursing Shift Supervisor's own supervisor if the Nursing Shift Supervisor was the author of the UOR, to review the UOR and complete the supervisor review. API should consider that the supervisor review should occur after the staff debrief, to ensure that information is part of the record reviewed by the supervisor.

Documentation of the incident does not always align with the information in the UOR. Medical chart notes are usually, but not always, written by staff with first-hand knowledge of the event. The Ombudsman suggested that API should consider having all staff involved in the incident author a note for the chart, with the senior staff involved writing the longer notes documenting restraint, seclusion, and other major events. PNA participants at the consultation explained that, as soon as an "unusual occurrence" concludes, the PNAs are on to other duties and tasks with patients. They explained that it was not practical to ask PNAs to author medical chart notes on every UOR. This is a reasonable concern, but API should still find a way to ensure that documentation is accurate and consistent.

The "less restrictive means" and interventions attempted prior to use of restraint or seclusion are consistently recorded as the same broad categories of "verbal intervention" or "redirection." While some staff take the time to describe the ways staff attempted to engage the patient to redirect or de-escalate prior to initiating a restraint, there are many UORs that do not clearly articulate the

active efforts to avoid restraint. It is possible that having staff with first-hand knowledge of what happened complete the documentation will allow for more detailed descriptions of active efforts to use less restrictive means. API should require that the supervisor reviewing the UOR check for detailed/descriptive information when they review the UOR and follow up with the author if necessary.

UOR documentation frequently did not clearly indicate the duration of a restraint or a seclusion. It could often be determined by reviewing the more extensive medical chart, but this reduces the value of UORs as a data and management tool. API should require that the supervisor reviewing the UOR check to ensure that duration is clearly included in the medical documentation.

The Ombudsman recognizes that the documentation required of health care practitioners – especially at API – is extremely burdensome. The time required to comply with documentation requirements is time taken away from patients. There could be opportunities to streamline the UOR documentation (which is currently a paper form completed by hand) and reporting at API while at the same time improving the accuracy and value of the information collected.

DHSS accepted this recommendation. API staff began training on "proper and consistent processes of documenting the UORS accurately and timely" on March 4, 2019.[202] "This includes noting the timing of each seclusion and restraint event."[203] A new Nursing Shift Report was implemented March 4, 2019 and staff were trained on "the importance of ensuring the information from the UORs aligns with the Nursing Shift Report."[204] Nursing staff have been designated to resolve discrepancies between medical documentation, Nursing Shift Reports, and UORs.[205]

[202] DHSS Response at 3-4.
[203] *Id.*
[204] *Id.*
[205] *Id.*

Recommendation 5: API should provide a clear explanation, in plain language, to all staff of the hospital restraint policy.

In his report on workplace safety and the environment at API, attorney Bill Evans stated:

> "The largest single issue impacting the overall work environment at API is the significant cultural divide that exists surrounding the issue of patient safety versus staff safety."[206]

He explained that "a large segment of staff" at API believe that oversight and enforcement of regulations related to use of seclusion and restraint have the effect of "reducing staff's ability to maintain safe control of the units."[207] This "cultural divide . . . permeates nearly all aspects of the workplace," which contributes to safety concerns in the hospital. [208] The Ombudsman's investigation corroborates these findings.

API policies and procedures, primarily SC-030.02.01, clearly prevent punitive use of restraint and limit use of restraint to situations posing "a clear and significant risk to the patient or others." However, staff interviews reflect a pervasive opinion that patients need to "submit" to staff authority, that patients are dangerous and need to be controlled, and that patients must experience consequences for failing to do as staff direct. Review of UORs related to use of restraint in 2018 showed that restraint or seclusion is sometimes used as a consequence for negative behavior that does not rise to the required level of creating an immediate or imminent risk of physical harm to self or others.

API should work with all staff to establish a shared understanding of what 42 CFR §482.13(e) requires. Staff should have a shared understanding of what constitutes a risk to the "immediate physical safety of the patient, a staff member, or others" so that patients are treated equitably and consistently throughout the hospital (and not depending upon who is working in what unit).

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[206] "Non-Confidential Public Report of Alaska Psychiatric Institute Investigation," Williams Evans, J.D. (September 7, 2018) at 4.
[207] *Id.*
[208] *Id.* at 6.

The Ombudsman understands that many, if not all, staff at API have experienced trauma at work. It is reasonable that some staff may interpret patient behaviors differently, and that what may feel threatening or unsafe to one member of staff may not be interpreted the same way by others. API should empower and equip supervisors to make decisions about the immediacy of the risk of harm based on as objective criteria as possible – while still allowing for professional discretion to assess and respond to crisis situations.

API unit managers should also ensure that responses to frequent or repeated patient behavior are consistent across shifts (i.e. behavior that day shift ignores should not result in seclusion during night shift). The disparities between day shift operations and night/weekend shift operations were highlighted by floor staff as well as management. Communication at shift change is compromised when staff leave early or arrive late. Some night and weekend shift staff report a lack of respect for their work, being treated as "babysitters" while day shift staff are treated as health care providers.

The Ombudsman considered making a recommendation related to chemical restraint. However, the health care practitioners at the consultation explained that even medications delivered properly in response to patient crisis could be considered "chemical restraint." Given the nuances and clinical ramifications of involuntary psychiatric medications, and the fact that involuntary medication is subject to judicial oversight, the Ombudsman believes that her concerns about the incident noted above can be addressed by API ensuring that all staff understand that no form of restraint – chemical or otherwise – can be used to punish a patient.

DHSS accepted this recommendation. DHSS reported that the restraint and seclusion policies had been reviewed, with revisions to be complete by March 15, 2019.[209] "Once the revised policy is approved and published, all staff will be trained and provided a detailed and clear explanation of the policy," by March 30, 2019.[210]

[209] DHSS Response at 4.
[210] *Id.*

Recommendation 6: API should work collaboratively with staff to mitigate and prevent challenging staff behaviors. Staff behaviors directly contribute to the patient behaviors. When staff engage in rude, dismissive, fearful, or negative behavior, that creates a barrier to effective treatment and milieu management.

DHSS accepted this recommendation. DHSS reported that API policies governing staff conduct toward patients had been reviewed, with revisions to be complete by March 15, 2019.[211] "Once the revised policy is approved and published, all staff will be trained and provided a detailed and clear explanation of the policy."[212] Training on the API Ethics Policy will be provided by March 30, 2019.[213]

Communication

API should prioritize open, direct, honest, and transparent communication with staff. All staff interviewed commented on the lack of trust in management ("the second floor") because they felt that either information was being kept from them, or the information they received was incomplete or inaccurate. It is noteworthy that the Ombudsman was contacted by several API staff on February 8, 2019 expressing anxiety and frustration that the decision to contract with a private management company had been made without notice to or opportunity for input from the staff who provide patient care and support services. One staff member commented that they feared that patient care would suffer because of how unsettled and fearful their colleagues were about the sudden change in management.

When implementing changes in practice or policy, API must provide information that is timely, accurate, and easily understood. API must also encourage and respond in good faith to feedback from staff. There is a pervasive lack of confidence that feedback will be received without retribution, or that any helpful action will be taken in response. It will take time, and the rebuilding of trust, to

[211] *Id.*
[212] *Id.*
[213] *Id.*

establish effective lines of communication between staff and management, but this is essential to change management and improving the efficacy of the mental health treatment provided.

DHSS responded that API hospital management and nursing leadership have developed a "plan of action" to improve the frequency and transparency of communications with staff.[214] DHSS committed to implement a significant change in how information is shared with API staff:

> Effective immediately, the facility leadership will communicate all issues related to survey outcomes and corrective action plans to nurse managers and staff I a timely manner and will work in close collaboration with the department staff to address any corrective actions/issue resolution, including requesting staff's input into the applicable process or policies revision.[215]

Equitable Treatment

Many staff reported a long history of favoritism in the way nursing staff were managed. API has made efforts to address that issue, and to treat staff more equitably. API should maintain its commitment to fair dealing and consistent management of all staff, while also improving communication within the hospital.

DHSS responded that "API Leadership will adhere to the "open-door" policy to promote confidence in staff communications with supervisors.[216] DHSS provided no comments related to the recommendation to ensure fair dealing and consistent personnel management.

Perpetual Learning

Most direct care staff interviewed reported that education was a "punishment" for when staff made a mistake. None of the direct care staff interviewed commented positively about the continuing education or training received after their initial onboarding. It appeared, however, that this was less about the quality of the education and more because hospital education was seen as remedial rather

[214] *Id.* at 4-5.
[215] *Id.* at 5.
[216] *Id.*

than as professional development. API should consider working toward creating an attitude of perpetual learning in the hospital, building upon the Alaska Psychology Internship Consortium (AK-PIC) and University of Washington WWAMI multi-state medical education programs.

DHSS provided no comments related to changing the dynamics or attitudes related to training and continuing education for API staff.

Staff to Strengths

As with any organization, API has staff with particular skills and aptitudes that allow them to work more effectively with some types of patients, or in some kinds of settings, than in others. During the consultation, participants agreed that patient care and the stability of the milieu improved when staff worked well as a team. API should establish staffing practices that assign PNAs and nurses to units based on their strengths, rather than their availability. API should also be willing to reassign staff to maximize their strengths. This would enhance the consistency of care in each unit, by allowing staff to complement each other's skills and experience and to develop a team dynamic. Staffing according to PNAs' and nurses' strengths will also reduce the number of incidents where staff over-react to or exacerbate patients' behaviors, leading to episodes of violence and/or the need for restraint or seclusion.

DHSS committed to implementing this recommendation:

> API will adopt the strategy of staffing the units according to individual staff member's strengths rather than availability, to promote unit cohesiveness and a team dynamic. The Human Resources department will be tasked with initiating this process beginning 4/1/2019. Wellpath is currently evaluating this specific issue at API and will submit a plan in accordance with their contract.[217]

[217] *Id.* at 5.

Immediate Accountability and Kudos

API clinical managers, Quality Assurance, Human Resources, and Hospital Education should work together to identify and respond to problematic staff behaviors as quickly as possible, and preferably before the behaviors become too challenging. By identifying early-on areas where a staff person is not following policy or best practice, and then offering coaching and education (rather than discipline), API is more likely to prevent bad habits from becoming ingrained.

API clinical managers, Quality Assurance, Human Resources, and Hospital Education should work together to identify and recognize when staff perform well, especially in difficult situations. This should also be done as quickly as possible. It not only reinforces the positive employee behavior but creates incentives for continued improvement by the staff at issue and their peers.

API should establish procedures for staff "kudos." Not all staff know that patients compliment them through the comment boxes. The 2017-2018 patient grievance data shows that 7% of patient comments were compliments of staff:

Many staff spoke of how meaningful it was when the former medical director would send a handwritten note of appreciation to staff by mail to their home. Those notes, often accompanied by a pin or other token, were valued by PNAs and nurses and provided the support they needed when the days were especially hard.

DHSS committed to implementing this recommendation: "API will implement a hospital-wide Employee Recognition Program" that includes monthly, quarterly, and annual events to recognize "staff who perform well, especially in challenging situations."[218] The Ombudsman appreciates this response, while noting that the positive reinforcement that API staff reported was most effective was the personal and direct communication from leadership (rather than an employee-of-the-month type of recognition).

[218] DHSS Response at 5.

Recommendation 7: API should continue to recruit and retain high quality health care professionals, ensuring that the staffing at the hospital is sufficient to provide effective inpatient psychiatric care even when the hospital is at full capacity (80).

Recommendation 7.1: The API Human Resources Department should be autonomous, not subject to the centralized recruitment and hiring processes coordinated through the Department of Administration.

There are insufficient dedicated human resources to meet the needs of the hospital. API currently shares an off-site human resources consultant at DHSS with the Alaska Pioneer Home. The human resources consultant is not supervised by or accountable to API management. API managers only have access to the consultant Monday-Thursday 8:00 a.m. - 4:30 p.m. While that may be reasonable for most state agencies, it does not meet the needs of a 24/7 acute psychiatric hospital.

Based on interviews with DHSS leadership and API staff throughout the investigation, it appears that the extensive recruitment and other human resources demands of the state psychiatric hospital have not been recognized for many years. API has been subject to hiring freezes and furlough requirements, even though it is required to provide critical hospital services to acutely ill patients all day, every day.

Funding for additional nursing positions at API was available July 1, 2018. Negotiations with the union and approval of the pay raises for nurses took several months, and recruitment for those positions could not begin until September 2018. The Ombudsman recognizes that some of the delays in hiring the additional staff funded in FY19 were outside of API's control. Unlike some other critical service agencies, API did not receive a specific waiver from the hiring freeze during Governor Walker's Administration.[219] Negotiations with the Department of Administration and the labor union over pay raises and bonuses complicated the already sluggish state hiring process. Long waits for

[219] *See* Memorandum from Chief of Staff Jim Whitaker to All Commissioners, August 24, 2016 re: Hiring Restrictions.

final approval of hiring decisions by the previous Governor's Office[220] resulted in some qualified candidates withdrawing their interest in positions at API.

Governor Walker and then Commissioner Valerie Davidson activated the Emergency Operations Center (EOC) to address the lack of treatment capacity at API on October 13, 2018. This EOC included a focus on staffing needs at the hospital. Pursuant to the EOC declaration, the Division of Behavioral Health assigned an additional 15 staff hours/week to API on November 5, 2018 to support hiring activities.[221] API anticipated hiring ten (10) new PNAs in November and December 2018.[222]

However, it appears that API's human resources demands still are not receiving the priority attention required. A classification study for the psychology positions at API was requested more than two (2) years ago but has not started.[223] The PNA position classification study that the Department of Administration was to have completed by December 2018[224] has not been provided to API. The nursing position classification study was supposed to be completed by the end of February or early March 2019.[225] The nursing salary review begun in FY18 is still not completed.[226]

The Ombudsman understands that the Department of Administration does not have unlimited resources and must provide human resources services to many state agencies. For this reason, API should have an autonomous, on-site Human Resources Department that is directly accountable to the hospital CEO and the API governing body. At a minimum, API should have a Human Resources Director; a consultant focused on staff grievances and labor relations; a consultant focused on workplace injury, medical leave, etc.; two (2) consultants dedicated to performance improvement and disciplinary matters; two (2) recruitment and hiring staff; one (1) position dedicated to staff

[220] All state recruitments after August 24, 2016 required approval from the Chief of Staff. The hiring freeze was modified but not lifted in January 2017. *See* Memorandum from Chief of Staff Scott Kendall to All Commissioners, January 6, 2017 re: Travel & Hire Restrictions. DHSS was granted a waiver in 2017 to help the Department recruit for essential staff (including but not limited to API).
[221] *See* DHSS Incident Action Plan, November 9, 2018 at 4.
[222] *See id.*
[223] *See* Interview of API Staff, February 8, 2019.
[224] *See id.*
[225] *See id.*
[226] *See id.*

background checks, preparing human resources records for surveys and audits, and reporting to licensing boards; a payroll clerk; and an administrative assistant.

DHSS declined to implement this recommendation, but noted that "all vacant clinical positions are being recruited."[227] The Ombudsman maintains this recommendation, based upon inability of the current human resources structure to respond to the recruitment, retention, and performance management needs of API in a timely or comprehensive manner.

Recommendation 7.2: API should prioritize recruiting and maintaining the health care workforce needed to provide treatment to all patients committed to API.

API currently lacks the psychiatrists needed to provide care to 80 patients. There are only three psychiatrists on staff currently. One physician serves as medical director and psychiatric director – and carries a patient load. This is not tenable. Reliance on *locum tenens* (temporary, traveling) physicians is not cost-effective – and it reduces the continuity of care for API patients. API has three physician assistants (all working under the medical director's supervision). API has two advanced nurse practitioners. API currently lacks sufficient forensic psychology staff to meet the demand for assessments for competency and restoration, which has created a months-long backlog.

In August 2018, API determined what additional staff the hospital would need to correct the deficiencies identified by CMS surveys:[228]

- 3 social workers
- 4 forensic psychologists
- 2 psychologists
- 1 advanced nurse practitioner
- 1 occupational therapist
- 5 recreational therapists
- 3 substance use disorder counselors
- 34 PNA II
- 14 PNA IV
- 9 maintenance/environmental services journey-level staff
- 1 accounting technician
- 1 administrative officer
- 2 office assistants

[227] DHSS Response at 6.
[228] *See* Interview with Duane Mayes, September 27, 2018.

The cost associated with expanding API's therapeutic and support staff to meet the needs of patients was estimated to be $7.056m per year.[229]

DHSS's response to this recommendation is that it "concurs," but provided no comment related to whether and how the Department plans to secure the additional health care professionals and support staffing identified by API as necessary to meet the needs of patients and to address the deficiencies identified by HCFLC and the Ombudsman:

> The Department concurs and has prioritized recruitment and training for a safe work environment to increase staff retention. Training staff with tools that work and giving them confidence in their ability to appropriately modify patient behavior is key to retention. Wellpath has instituted a true Root Cause Analysis process for every incident and involves all staff in the process. This has proven to be immediately effective in engaging staff and giving them a new way to approach difficult situations.[230]

The Ombudsman maintains the recommendation that DHSS ensure that API has adequate psychiatrists, psychologists, therapists, nurses, and psychiatric nursing assistants to safely and effectively provide psychiatric treatment to patients.

Recommendation 7.3: API should commission a classification study, preferably by an expert in psychiatric inpatient hospital staffing, to ensure the PNA series accurately reflects the extensive expectations placed upon PNAs for the direct care and treatment of patients. The Ombudsman understands that the Department of Administration has undertaken a classification study of the PNA series, but it has not been provided to API as of the date of this writing.

Based on the investigation and many interviews with PNA and nursing staff, it is clear that **PNAs bear the greatest responsibility for patients' care, and often spend the most time with patients while they are undergoing treatment at API.** However, the skills and experience required for an

[229] *See id.*
[230] DHSS Response at 6.

entry level PNA are simply a high school diploma or GED. No knowledge or training related to mental health or health care is required.

Comments from some members of API management to the Ombudsman during the investigation indicated a lack of respect for the work PNAs do. This lack of respect is also reflected in the compensation afforded to PNAs. A PNA I is a range 9 – a starting salary of $2,678/month. A PNA IV is a range 14 – a starting salary of $3,644/month. A classification study will provide the opportunity to align the work PNAs are asked to perform every day to the position description, requirements, and compensation.

DHSS declined to implement this recommendation, citing the pending classification studies at the Department of Administration.[231] Given the evidence that API's human resources needs have not been prioritized by the Department of Administration in the past, and that the PNAs provide a specialized health care service within a unique environment in the state system, the Ombudsman maintains the recommendation that the Department pursue reclassification by an organization with expertise in hospital management to better align the qualifications and compensation of the PNA series.

Recommendation 7.4: API should implement a mentoring program for new hires, matching new employees with experienced staff (who have demonstrated high levels of proficiency and adherence to best practices) for a meaningful period of time. At the consultation, the PNAs described the value of the mentoring they received when they joined API years ago – and shared frustration that some newly hired (as well as some incumbent) PNAs do not have the basic skills required for the job.

DHSS committed to implement this recommendation: "API Hospital Education and Human Resources . . . will ensure the formal mentorship and competency evaluation program for PNAs is implemented by May 1, 2019."[232]

[231] *See id.*
[232] *Id.*

Recommendation 7.5: API should expand the Recovery Support Services Department to provide adequate peer support, patient advocacy, and patient grievance services, including evenings and weekends.

The Recovery Support Services Department is currently staffed by one manager and one peer support specialist. The peer support specialist reports spending most of his time on patient grievances and administrative tasks, rather than providing peer support and advocacy to patients. There are no peer support resources available to patients admitted on weekends or evenings, which means that nursing staff lack a critical resource for making admissions less traumatic for patients. Peer support and advocacy should be available to patients beyond just the usual Monday-Friday business day.

The volume of patient grievances is substantial, and API has been cited by CMS for failure to process and respond to grievances timely. Not only is it essential that API respond to these grievances according to law and policy – patient feedback is an invaluable source of information about the day-to-day effectiveness of the services API provides. Grievances are a valuable source of information to API as it seeks to resolve deficiencies and improve services. Thus, having at least one member of staff dedicated to processing and responding to patient grievances, and tracking them through the higher levels of resolution, is critical.

DHSS accepted this recommendation, responding that "API is committed to expanding its Recovery Support program services" and has the "goal of having services available to patients 7 days a week."[233] DHSS also responded that "the patient advocate will be appointed as the responsible party for addressing all patient grievances and complaints"[234] – which is already a responsibility of the two staff in the Recovery Support Services Department.

[233] *Id.*
[234] *Id.*

Recommendation 8: API should expand active treatment delivered to patients until a significant portion of the day, including weekends, involves evidence-based psychiatric and behavioral health care.

When the Ombudsman initiated the investigation, active treatment was not being delivered consistently every day on the units. While school/education services are provided on the Chilkat Unit during the school year, they are not offered in the summer – leaving long periods of unoccupied time for patients.

API has long had a treatment model of acute care and stabilization. However, API does not currently deliver the active treatment services needed to address the intensive needs of the most acutely mentally ill. API should have staff on-site with the skills, experience, resources, and supplies needed to offer active treatment appropriate to address the specific symptoms and needs of patients Monday through Friday and on weekends. There should also be clinical staff (a psychologist or other mental health professional) available until 7:00 p.m. to support staff on the units when responding to challenging or crisis situations.

Over the course of the investigation, and in response to findings by various licensing and accrediting bodies, API has started to increase the active treatment services provided. However, active treatment requires therapeutic capacity API does not have. As discussed above, API has identified the clinical positions needed to provide adequate psychology, social work, recreational therapy, occupational therapy, and other clinical services. These are critical to efforts to provide adequate active treatment at API.

DHSS accepted this recommendation and committed to presenting a proposal for "a revised, more vigorous treatment module program" by May 1, 2019.[235] DHSS pointed to the active treatment model being introduced by Wellpath that includes "six hours of active therapy a day per patient."[236]

[235] *Id.* at 7.
[236] *Id.*

Recommendation 9: API should fully implement individualized treatment plans, developed by a multidisciplinary team in partnership with the patient, and should ensure that treatment plans are modified appropriately based on patient progress or lack of progress and the observations of all staff engaged in the patient's care.

API reportedly has an excellent treatment planning tool. However, too often patients are given "cookie cutter" treatment plans developed by one member of a treatment team with little input from the patient or the staff who engage most directly with the patient. API should define the multidisciplinary treatment team to specifically include the patient's primary care provider, psychiatrist, licensed psychologist, recreational or other rehabilitative therapist, licensed independent practitioner, social work discharge planner, and teacher (if an adolescent). Hospital Education should also have a representative at treatment team meetings, so that any training or continuing education resources needed can be identified and delivered.

Recommendation 9.1: API should require face-to-face meetings of the full multidisciplinary treatment team, with the patient, each week and whenever a significant change occurs in the patient's symptoms or behavior.

DHSS responded that "staff will be encouraged to increase the number of disciplines" who meet with patients to develop and update their treatment plans.[237]

Recommendation 9.2: API should require than a PNA IV familiar with the patient and their care and progress (and preferably who has established a rapport with the patient) to be part of the patient's multidisciplinary treatment team. The PNA IV should be included on all treatment team meetings.

At the consultation, participants reported that PNAs are now being included in treatment team meetings, which the Ombudsman appreciates. However, the Ombudsman notes that this recommendation was also made by the Alaska Mental Health Board in 1998, but wasn't implemented

[237] *Id.*

until 2000.[238] The practice fell away sometime after the current hospital opened. Thus, the Ombudsman has maintained the recommendation to ensure that recent inclusion of PNAs on treatment teams continues.

DHSS accepted this recommendation and committed to include a PNA familiar with the patient at each treatment team meeting, and to confirm participation through review of treatment plans and documentation.[239]

Recommendation 10: API should make Hospital Education an independent department within the hospital, with the director becoming part of the senior management team and the addition of educator positions sufficient to onboard and support the large number of new hires needed in 2019-2020.

Hospital Education is a crucial part of API, ensuring that staff have the education, training, and tools they need to effectively deliver services. In the past two years, Hospital Education has moved from the Nursing Department to Quality Assurance, only to be suddenly and without notice moved back to the Nursing Department in the summer of 2018. Hospital Education is responsible for significant duties related to Quality Assurance, even after being moved out of that department. This creates a conflict of interest between the goals of the Nursing Department and Hospital Education.

Hospital Education plays a pivotal role in the implementation not only of the Ombudsman's recommendations, but the changes identified by API in successive Plans of Correction. Hospital Education must have the authority and resources it needs to achieve API's goals for staff training and continuing education. Hospital Education should be a partner, and not subservient to, Quality Assurance and the clinical departments.

DHSS accepted this recommendation, reporting that the Hospital Education Department "was already transitioned to be independent from the Nursing Department in mid-February [2019]" and

[238] *See Alaska Psychiatric Institute, FY 2000 Review,* Alaska Mental Health Board Program Evaluation and Review Committee (February 16, 2000) at 25.
[239] *See* DHSS Response at 7.

that a "Hospital Education representative" is participating on the senior management team, quality assurance committee, and safety "huddle."[240] DHSS did not provide comment on the need for additional educator resources in the Hospital Education Department, but did note that Wellpath has provided the opportunity for additional staff training.[241]

Recommendation 11: API should provide trauma-informed supervision, support, and on-site counseling for staff.

DHSS contracted with attorney Bill Evans to review issues related to staff safety at API, which is why this issue was not investigated by the Ombudsman. However, the fear and trauma reported by most if not all staff interviewed at length by the Ombudsman is a contributing factor to the episodes of violence, restraint, and seclusion at API – because staff are responding in ways affected by their own past traumatic experiences at API. While there is a great deal of research and evaluation related to providing trauma-informed care, there are few resources available to supervisors who manage highly traumatized staff. API should work with Hospital Education to identify evidence- and practice-based resources for supervisors (or potentially develop resources with Alaskan experts) so that they can better manage and support staff before, during, and after crisis situations.

Staff expressed a desire for access to confidential resources, such as a trained chaplain or counselor, at API to help process stress and trauma experienced at work. This could potentially be done in partnership with CISM-trained[242] chaplains from the Alaska Police and Fire Chaplains, or the Anchorage area emergency responder chaplains, or the Employee Assistance Program offered to state employees to offer on-site debriefs and individual counseling.

DHSS did not accept this recommendation. DHSS responded that "API staff received training in trauma-informed care" but did not address the need to provide resources and training to

[240] *Id.*
[241] *See id.*
[242] Critical Incident Stress Management is an evidence-based model of debriefing and supporting individuals after a traumatic event. It is a short-term, time-limited intervention delivered soon after a traumatic event (suicide, workplace shooting, natural disaster, etc.) to assist people in understanding their emotions and reactions to the event and connecting them to additional supports and services if needed.

supervisors of staff experiencing primary or secondary trauma.[243] DHSS also responded that "staff who experience stress and trauma at work will be referred to the Employee Assistance Program effective immediately."[244] This is the minimum response of an employer after a major critical incident (like a natural disaster) or a member of staff is harmed. DHSS offered that API staff needing support could also contact Dr. Kevin Ann Huckshorn, a consultant working for or with Wellpath.[245] The Ombudsman maintains the recommendation to have confidential on-site counseling and support resources available for staff experiencing stress and/or trauma.

Conclusion

The Ombudsman and her staff had the opportunity to speak at length with API administrators, managers, doctors, psychologists, social workers, nurses, psychiatric nursing assistants, advocates, and patients. Every member of staff interviewed spoke not just about the problems and deficits at API, but also about assets present at API. Each person interviewed identified a colleague they felt provided good care to patients, or strong support for staff. In their own ways, each expressed hope for the hospital's future. Not all staff have the same vision for the hospital, nor do they share the same perspectives on patient care, but staff do share common goals and values that will help API implement the recommendations made to overcome the systemic issues identified by this investigation.

[243] DHSS Response at 8.
[244] *Id.*
[245] *See id.*